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## Study Of Clinical Profile And Short-Term Outcomes Of Dissociative Disorder In Adolescents-An Observational Study In A Tertiary Care Centre.

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### ABSTRACT

Though a substantial number of studies indicate the nexus between childhood trauma, PTSD, and dissociative disorders among adolescents, Indian literature is mostly silent. As reported incidents of child abuse are alarming in India, it was important to explore further on the subject. To explore the relationship between childhood trauma and other clinical correlates like anxiety, PTSD and behavioral problems in adolescents diagnosed with dissociative disorder. 50 adolescents aged 13-18 years with a diagnosis of dissociative disorder were included. A convenient sampling technique was used to recruit the patients from child guidance clinic of the tertiary care hospital in Chittoor district between July 2023 - December 2023. Child Dissociative Checklist (CDC), Children's Impact of Events Scale (CRIES -13), *Screen for Child Anxiety related Emotional Disorder (SCARED)*, and Youth self-Report (YSR from Child Behavior Checklist) were administered. The sample consisted of 62% females and 38% males. A significant relationship was found between dissociation and anxiety, panic disorder and separation anxiety disorder. CDC had a positive correlation with internalization, externalization, and behavioral problems. Regression analysis showed that behavioral problems and PTSD (CRIES-13) as two significant predictors of anxiety. The findings indicated that dissociation had a significant association with childhood trauma, behavioral problems, anxiety, and post-traumatic stress. Thus, culturally appropriate trauma-focused interventions for the treatment of mental illnesses and the underlying trauma should be designed for addressing dissociative disorders in this age group.

**Keywords:** Dissociative disorders, Childhood Trauma, Adolescents, PTSD, Behavioral Problems

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## INTRODUCTION

Dissociation is defined as a disruption of the normal integration between memories, immediate sensations, control of bodily movements and identity. Dissociation means disassociating one's own feelings and thoughts from consciousness. It is a state where a person may feel detached from oneself and his/her surroundings as if he is disconnected from his own body and the world around him looks unreal to him. This dissociative experience can last for a brief period of time or up to hours/days. Briere [1] described dissociation as "a defensive mechanism which creates disruption in feelings, thoughts, behavior and memories of an individual. Dissociation normally occurs as a response to a traumatic event or in the face of a stressful situation where a person finds difficult to cope with. It is assumed to be pathological in nature because of its negative impact on the psychological well-being of individuals. Dissociation in children and adolescents is not uncommon. It can result from alterations in normal- integrative functions of the psyche which gets reflected in terms of altered identity, memory, and consciousness. But it has also been manifested as disturbances of sensation and motor functions. It is well known that psychological stress/Trauma can lead to both physical and psychiatric symptoms. If an individual is exposed to multiple traumatic events during childhood, he is likely to adapt dissociation as a self-regulatory mechanism that will affect the mental and behavioral functioning of these children. Excessive activation of the dissociation becomes a pathological organizer of emotions and feelings and may lead to severe psychopathology [2,3]. Dissociation as a defensive reaction in children who faced severe and repeated traumatic events was also discussed by Coons [4]. Traumatized children, when face with memories of the traumatic event, may experience so much pain and anxiety that they become overwhelmed and psychologically disturbed. In these situations, when they cannot physically withdraw from the situation, they try to dissociate themselves from those traumatic memories through various defensive functions. The lack of coping skills among young children will make them more prone to dissociation in the face of traumatic situations and supporting the view that trauma is often linked to pathological dissociation [5]. In India, a significant number of children and adolescents are exposed to traumatic life events at an early age. A traumatic event not only threatens the physical integrity of self but also destroy the psychological mechanism of Children and adolescents during the developmental years. In order to cope, they use various defensive functions to avoid thoughts and memories of a traumatic event or to gain control over the event. As a result, they will report various somatic complaints, impairment in memory, motor difficulties, regression, and conversion. Culture will also have the greatest influence on the clinical presentation. In Indian culture, the dissociation is quite prevalent from ancient times and was initially considered as "Bhoot Bhadha" (possession), but now it has been accepted as a mental disorder that occurs as a reaction to psychological stress, strain or trauma. In India, dissociative trance, possession, sensory and motor difficulties are commonly found in clinical settings among children and adolescents. Most of the studies have supported female preponderance [6-8] and younger age [7] and change in nature of symptoms with increasing age [9]. Although there is an increasing global agreement on the association of childhood trauma and dissociative disorder [10-13], clinical and research interest in dissociation has increased over the last two decades. Persons who are having a history of traumatic experiences or continuous trauma in their life may be more vulnerable to a variety of dissociative states and may present somatic, depressive anxiety symptoms, and PTSD symptoms [14-16]. Research in India is limited to very few descriptive and review studies. Further, the relationship between childhood trauma and psychiatric morbidities has not been studied in the Indian context to the best of our knowledge. Thus, the present research explores the relationship between childhood trauma and various other psychological correlations like Anxiety, PTSD, and Behavioral problems associated with traumatic experiences in adolescents diagnosed with dissociative disorder.

## METHODS

A convenient sampling technique was used to recruit the patients from child guidance clinic of a tertiary care hospital in Chittoor District between July 2023 - December 2023. we enrolled 50 adolescents (both male and female) who attended child guidance clinic in the hospital, who fulfil the following criteria: (1) age between 13- 18 years, (2) A Psychiatric diagnosis of dissociative disorders using ICD-10 diagnostic criteria, (3) absence of mental retardation, (4) absence of severe mental illnesses such as psychotic disorders, bipolar disorders, and disorders of psychological development, and (5) written informed consent provided by the parents or the legally accepted relatives. A semi-structured interview schedule was used to obtain the demographic data, details on personal history, nature of traumatic events, clinical symptoms and co-morbidities if any existed. Both adolescents and their family members were interviewed by the clinician. With substantial expertise to gather detailed information about the possibility of any adverse psychological event (stressor) or trauma in the past and its apparent consequences for the child. We

considered it as a "trauma" experience of sexual abuse, physical abuse, witnessing domestic violence, bullying at school, the sudden death of loved ones, witnessing a suicide in the family, alcoholism in father, emotional neglect and terminal medical illness. These experiences were screened as per adolescents' own viewpoints without the assistance of caregivers/parents. The parents confirmed whether the incidents happened before the onset of dissociative symptoms or not. All three cases of sexual abuse incorporated in the study were already reported by the parents and family members. After the clinical evaluation, all participants were administered the following psychometric instruments. (Tests and self-report scales). Child Dissociative Checklist –CDC [17] - records observation of a parent/ family member about a child's present behavior and in the last 12 months on a 20-item list. The test can quantify dissociative behavior as a single score and provides cut-off scores that categorize children/adolescents into low and high dissociation groups. The Child Dissociative Checklist (CDC) is having a test-retest reliability coefficient of  $\rho = .69$  in a sample of normal and sexually abused girls. It has good discriminant validity among four test samples, including normal control girls, sexually abused girls, boys and girls with dissociative disorder NOS and boys and girls with multiple personality disorders. Children's Impact of Events Scale (CRIES)-13 [18] - measures the impact of adverse events in a child's life. CRIES-13 is used to understand the post-traumatic stress disorder (PTSD) phenomenon of re-experiencing the traumatic event, arousal, and avoidance of that event. It consists of 13 items, and the response is recorded on a four-point scale. The test is having three subscales of Intrusion, Avoidance and arousal. Reliability coefficients in terms of internal consistency range from .75 to .87 for the total CRIES-13, and the cut off score is 30 above, which a score is assumed to be significant. Screen for Child Anxiety related Emotional Disorder (SCARED) [19] - is a widely used measure to assess childhood anxiety and is a parent and self-report questionnaire (41 items). It is used to screen for childhood anxiety disorders, including generalized anxiety disorder, separation anxiety disorder, panic disorder and social phobia. The SCARED is having moderate to high internal consistency ( $\alpha=0.43-0.89$ ), moderate parent-child correlation ( $r=0.49-0.59$ ) and good discriminant validity (between anxiety and non-anxiety disorders).

**Statistical Analysis**

The Kolmogorov-Smirnov test was used for confirming the normal distribution of all the non-categorical variables. Descriptive statistics in terms of means and standard deviation (SD) and percentages are used for Continuous and categorical variables. Pearson correlation coefficient was used to find the association between traumatic experiences and dissociation, PTSD, behavioral problems, and anxiety disorders. Stepwise regression analysis was conducted to determine whether behavioral issues, anxiety, and PTSD symptoms are the significant contributors/ predictors of dissociation or each other. The statistical analysis was conducted using SPSS software Version 21, and the level of significance was set at less than 0.05 level.

**RESULTS**

**Demographic profile**

**Table 1: Demographic Characteristics of the patients (N=50)**

| Variable                 | Frequency (%)         |
|--------------------------|-----------------------|
| Gender                   | 31 (62)               |
| Female                   | 19 (38)               |
| Male                     |                       |
| Socio-economic Status    | 38 (76)               |
| Middle                   | 7 (14)                |
| Lower                    | 5 (10)                |
| Upper                    |                       |
| Family Background        | 27 (54)               |
| Urban                    | 23 (46)               |
| Rural                    |                       |
| Support                  | 47 (94)               |
| Family Support           | 3 (6)                 |
| No Family Support        |                       |
| Mean Age of Participants | Mean=14.50 (SD=2.573) |

The sample consisted of 62% females and 38% males. The mean age of the participants was 14.50

(SD=2.573), and the mean age of onset of the dissociative disorder was 13.40 (SD=2.673). The majority of the patients (76%) belonged to middle SES, followed by lower SES (14%) and upper class (10%). Out of the total sample, 54% of patients belonged to urban areas, and 94% reported having good family support (Table-1).

**Clinical Profile**

The past history of experiencing any type of trauma in their life was reported by 62% of patients, whether it was bullying in school (20%), domestic violence (18%), medical illness (14%), sexual abuse (6%), loss of loved ones (2%), and physical abuse (2%). 12% of the patients reported having a family history of psychiatric illness. The crosstab analysis showed that out of all those who are having a h/o of trauma, 46% were high on anxiety, 32% were high on PTSD symptoms, 22% had behavioral problems, and 14% had dissociation. While 68% (N=34) of adolescents were above the cut-off scores of the anxiety scale, 44% (N=22) had qualified for having PTSD, 30% (N=15) had significant behavioral problems, and 22% (N=11) had significant dissociation currently (Table-2).

**Table 2: Clinical Profile of the Patients (N=50)**

| Variables                                             | Frequency (%)            |
|-------------------------------------------------------|--------------------------|
| Past H/O Traumatic Stress                             | 31 (62)                  |
| Traumatic Stress                                      | 19 (38)                  |
| No Trauma                                             | 10 (20)                  |
| Evident Bullying at School                            | 9 (18)                   |
| Domestic Violence                                     | 7 (14)                   |
| Medical Illness                                       | 3 (6)                    |
| Sexual Abuse                                          | 1 (2)                    |
| Physical Abuse                                        | 1 (2)                    |
| Sudden loss of loved ones                             | 0                        |
| Neglect                                               | 0                        |
| Clinical Profile>cut off score<br>CRIES-13 (PTSD)     | 22 (44)                  |
| Clinical Profile>cut off score Anxiety scale (SCARED) | 36 (72)                  |
| Separation Anxiety                                    | 30 (60)                  |
| Panic Disorder                                        | 26 (52)                  |
| School Avoidance                                      | 22 (44)                  |
| Generalised Anxiety Disorder                          | 21 (42)                  |
| Anxiety                                               | 12 (24)                  |
| Family History of Psychiatric illness- Present        | 6 (12)                   |
| Age of onset of Dissociation                          | Mean=13.40<br>(SD=2.673) |

Findings showed that 72% of the total sample reported having any form of anxiety disorder on SCARED. Out of these, 60% had separation disorder, 52% had panic disorder, 44% of them were found to be high on school avoidance, 42% had GAD, and 24% reported social anxiety. On CRIES (Children's Impact of Events Scale) 44% of adolescents had a significant PTSD score.

**Outcome Measures**

Table-3 showed that anxiety had significant associations with dissociative disorders ( $r=.361^{**}$ ,  $p<_.010$ ) and PTSD ( $r=.470^{**}$ ,  $p<_.001$ ), which indicated that all those patients who were high on anxiety also had a high score on PTSD and dissociation. A significant correlation was found between dissociation and panic ( $r=.447^{**}$ ,  $p<_.001$ ), GAD ( $r=.537^{**}$ ,  $p<_.000$ ) and separation anxiety disorder ( $r=.282^{*}$ ,  $p<_.047$ ) which indicated that children diagnosed with dissociation also experienced panic attacks, generalized anxiety and separation anxiety and PTSD. An increase in dissociation scores on CDC also significantly increased scores on internalization ( $r=.429^{**}$ ,  $p<_.002$ ), externalization ( $r=.579^{**}$ ,  $p<_.00$ ), and total score of behavioral problems ( $r=.528^{**}$ ,  $p<_.00$ ) such as withdrawn behavior ( $r=.378^{**}$ ,  $p<_.007$ ), thought disturbance ( $r=.463^{**}$ ,  $p<_.002$ ), attention difficulties ( $r=.391^{**}$ ,  $p<_.005$ ), rule breaking behavior

( $r=.561^{**}$ ,  $p<.00$ ) aggression ( $r=.480^{**}$ ,  $p<.00$ ) and others ( $r=.279^{**}$ ,  $p<.049$ ).

**Table 3: Pearson Correlations between CDC and YSR, SCARED, and CRIES and CRIES with SCARED**

| YSR                |                           | CDC            |                           | CRIES. 234, .10                    |
|--------------------|---------------------------|----------------|---------------------------|------------------------------------|
|                    |                           | SCARED Anxiety |                           | CRIES with SCARED                  |
| Depression         | .212, .140                | Anxiety        | .361 <sup>**</sup> , .010 | Anxiety.470 <sup>**</sup> , .001   |
| Withdrawn          | .378 <sup>**</sup> , .007 | Panic          | .447 <sup>**</sup> , .001 | Panic.489 <sup>**</sup> , .000     |
| Somatic            | .216, .132                | GAD            | .242, .090                | GAD.537 <sup>**</sup> , .000       |
| Thought            | .436 <sup>**</sup> , .002 | Separation     | .282 <sup>*</sup> , .047  | Separation.342 <sup>*</sup> , .015 |
| Attention          | .391 <sup>**</sup> , .005 | Social         | .275, .053                | Social .068, .638                  |
| Rule breaking      | .561 <sup>**</sup> , .000 | School         | -.103, .475               | School.194, .178                   |
| Aggression         | .480 <sup>**</sup> , .000 |                |                           |                                    |
| Others             | .279 <sup>*</sup> , .049  |                |                           |                                    |
| Internalization    | .429 <sup>**</sup> , .002 |                |                           |                                    |
| Externalization    | .579 <sup>**</sup> , .000 |                |                           |                                    |
| Behaviour Problems | .528 <sup>**</sup> , .000 |                |                           |                                    |
|                    |                           |                |                           |                                    |

<sup>\*\*</sup>. Correlation is significant at the .01 level, <sup>\*</sup>significant at the 0.05 level (2-tailed)

Table-4 presented the findings of stepwise regression analysis on anxiety as a dependent variable and all relevant demographic (e.g. age, age of onset of illness, duration of illness, education, socio-income status) and outcome variables as independent variables. Findings revealed that behavioral problems and PTSD (CRIES) were two significant predictors of anxiety with a  $r^2$  value of .409. The beta coefficients were .452,  $p=.000$  and .342,  $p=.005$ , respectively. This indicated that around 40% of the anxiety could be explained due to the presence of behavioral issues and PTSD symptoms and as behavior problems and PTSD symptoms increase, the anxiety also worsened significantly.

**Table 4: Regression Analysis on Anxiety**

| Model              | R    | R Square | Unstandardised Coefficient |            | Standardised Coefficient |        | Sig. |
|--------------------|------|----------|----------------------------|------------|--------------------------|--------|------|
|                    |      |          | Beta                       | Std. Error | Beta                     | t      |      |
| (Constant)         |      |          | -9.420                     | 8.527      |                          | -1.105 | .275 |
| Behaviour Problems | .549 | .301     | .575                       | .149       | .452                     | 3.863  | .000 |
| CRIES Total        | .639 | .409     | .436                       | .149       | .342                     | 2.928  | .005 |

Dependent Variable: Anxiety on SCARED

Table-5 presented the findings of stepwise regression analysis on PTSD as a dependent variable and all other demographic (e.g. age, age of onset of illness, duration of illness, education, socio-economic status) and outcome variables as independent variables. Moreover, this revealed that generalized anxiety, social anxiety, and panic attacks were the significant predictors of post-traumatic stress disorder. Beta coefficients revealed that generalized anxiety and panic attacks contributed positively to elevating PTSD scores.

**Table-5 Regression Analysis on PTSD**

| Model                      | R    | R Square | Unstandardised Coefficient |            | Standardised Coefficient |        | Sig. |
|----------------------------|------|----------|----------------------------|------------|--------------------------|--------|------|
|                            |      |          | Beta                       | Std. Error | Beta                     | t      |      |
| (Constant)                 |      |          | 2.946                      | 2.990      |                          | .985   | .330 |
| Generalized Anxiety        | .537 | .289     | .1484                      | .336       | .537                     | 4.413  | .000 |
| Social Behavioral problems | .632 | .399     | -1.422                     | .484       | -.421                    | -2.935 | .005 |
| Panic attack               | .678 | .459     | .574                       | .253       | .303                     | 2.269  | .028 |

Dependent Variable: PTSD on CRIES



Table-6 presented the findings of stepwise regression analysis on child dissociative checklist as a dependent variable and all other demographic (e.g. age, age of onset of illness, duration of illness, education, socio-income status, childhood trauma, family history of psychiatric illness, social support received) and outcome variables as independent variables. And this revealed that externalized behavioral problems, school avoidance, panic or somatic symptoms, rule- breaking behavior, social support, history of childhood trauma, attention problems emerged as significant predictors of dissociative disorders. Beta coefficients revealed that while externalised behavioral problems contributed 50% variance, trauma contributed 20% variance in elevating CDC scores. However, there were no significant male-female differences on any outcome variables.

**Table 6: Regression Analysis on CDC**

| Model                                                                              | R                 | R Square | Unstandardised Coefficient |            | Standardised Coefficient |        | Sig. |
|------------------------------------------------------------------------------------|-------------------|----------|----------------------------|------------|--------------------------|--------|------|
|                                                                                    |                   |          | Beta                       | Std. Error | Beta                     | T      |      |
| (Constant)                                                                         |                   |          | -3.313                     | 2.400      |                          | -1.381 | .174 |
| a. Predictors: (Constant), Externalization T                                       | .579 <sup>a</sup> | .335     | .210                       | .043       | .579                     | 4.917  | .000 |
| b. Predictors: (Constant), ExternalizationT, SchoolT                               | .623 <sup>b</sup> | .389     | -.553                      | .273       | -.237                    | -2.029 | .048 |
| c. Predictors: (Constant), Externalization T, School T, Panic T                    | .687 <sup>c</sup> | .472     | .240                       | .089       | .335                     | 2.693  | .010 |
| d. Predictors: (Constant), Externalization T, School T, Panic T, Rule T            | .736 <sup>d</sup> | .542     | .402                       | .153       | .391                     | 2.622  | .012 |
| e. Predictors: (Constant), School T, Panic T, Rule T                               | .726 <sup>e</sup> | .528     | .532                       | .107       | .518                     | 4.990  | .000 |
| f. Predictors: (Constant), School T, Panic T, Rule T, Support                      | .762 <sup>f</sup> | .580     | 4.141                      | 1.744      | .238                     | 2.375  | .022 |
| g. Predictors: (Constant), School T, Panic T, Rule T, Support, Trauma              | .787 <sup>g</sup> | .620     | .441                       | .205       | .203                     | 2.148  | .037 |
| h. Predictors: (Constant), School T, Panic T, Rule T, Support, Trauma, Attention T | .810 <sup>h</sup> | .657     | .341                       | .159       | .239                     | 2.142  | .038 |

Dependent Variable: Dissociation on CDC

**DISCUSSION**

The present study attempted to assess the relationship between childhood trauma, anxiety, PTSD and behavioral problems among adolescents diagnosed with dissociative disorder. For this purpose, an exploratory study was done on dissociative adolescents. The clinical sample had a majority of female cases in an age group of 13-18 years and reported experiencing some form of trauma in childhood, whether it's Sexual Abuse, domestic violence, bullying at school, loss of loved ones and medical illness. The age of onset of traumatization was found in early adolescence, and a high percentage of the history of trauma in the sample was in line with the previous findings supporting the fact that dissociation is highly prevalent among adolescents, specifically among girls, who have experienced any kind of emotional trauma in their past.[21] A positive relationship between age and anxiety disorders was found, which means that the anxiety symptoms were evident more among middle and late adolescents. The descriptive findings show that the anxiety was quite high among these adolescents as the majority of them reported anxiety symptoms on SCARED. Separation anxiety was reported by more than half of the sample of adolescents, followed by Panic and somatic symptoms, School avoidance, GAD and social problems. Similar research also suggest that children exposed to traumatic incidents are more prone to developing post-traumatic stress disorder [12]. Traumatized children have a possibility of developing somatic complaints, low mood/ depression, poor interpersonal functioning, cognitive disturbance and dissociative symptoms [13]. In the present study,

Attention-concentration was poor among the majority of the cases. Apart from these other clinical symptoms like withdrawn behaviour and somatic complaints, social problems and thought disturbance, aggression and depression were also found among a significant number of adolescents. The findings are also supported by the study done by Dixit et al. [22], who got similar findings and suggested that traumatic events and their consequences can cause cognitive dysfunctions along with somatic complaints about Children who have experienced trauma and thus affect their functioning. History of traumatic experiences reported in the sample showed Around one- third of the patients did not report any apparent exposure to traumatic experiences in their past life. Although, those who reportedly did not mention a high number of traumatic experiences as the majority of them reported 1 or 2 (few) traumata. The most frequent traumatic experiences occurring in the sample were bullying at school and witnessing domestic violence, while the less frequent were sexual and physical abuse. Findings show a significant association between anxiety, CRIES and CDC, which means that anxiety and dissociative disorders are closely related. Further, PTSD and anxiety disorders were also found to be significantly associated, which shows that all those children who were high on anxiety also had a high probability of developing PTSD. Children who were having PTSD symptoms were also found to have symptoms of panic, anxiety and separation anxiety. Further dissociation was also found to be positively correlated with Internalization, Externalization and Behavioral problems. These children were having a significant association with withdrawn behavior, social problems, thought disturbance, attention difficulties, rule- breaking behavior and aggression. Looking at the data retrospectively also provides us with important information. It was found that there is a close association between trauma experienced at an early age and the tendencies to dissociate. In the present study, the mean age of onset was in early adolescence. So, it can be inferred from the findings that children who experienced trauma in their early life or their early childhood are more likely to dissociate than those who experienced the trauma in their later life. Further, it also depends on their nature and severity of trauma. If the trauma was severe enough and continued over a longer period, then the children will have more severe consequences in the form of PTSD and personality disorders. Regression analysis shows that behavior problems among adolescents and traumatic life events are the two significant predictors of anxiety, which means that the presence of traumatic events resulting in PTSD and behavioral problems contributed positively towards more dissociative problems. In the present study, both behavioral problems and trauma history were significantly related to dissociation. Adolescents with behavioral issues like aggression, disobedience, poor attention manifested poor social relationship and withdrawn behavior. Traumatic events have features outside the range of normal experience, and it leads to a set of physical, mental and behavioral responses. Sometimes when fighting is not possible, the child will use avoidant and maladaptive coping mechanisms that are dissociation. The intensity of the dissociation may vary with the severity and duration of the traumatic event. This shows that the trauma itself may be a contributing factor for adopting an escape mechanism like dissociation where the self can be protected by dis-associating one's thoughts from the painful memories and suppressing them into unconsciousness. However, in the long term, this mechanism can further disrupt and impair a person's life and functioning. Our findings get support from other studies [23], who similarly found that there is a very strong link between trauma and dissociative disorders, and the relationship is important in both directions. Apart from this, dissociation and PTSD are also closely related and frequently occur together, and sometimes dissociative disorders to be a subtype or subset of PTSD [24]. Mann-Whitney U test was computed to find out the gender differences between trauma, anxiety, CREST, CDC and behavior problems. Findings reveal that no significant gender difference was found in anxiety, CREST, CDC, and behavioral problems. So, both male and females are equally at risk of developing anxiety, PTSD and behavior problems because of traumatic experiences. In literature, many studies have tried to find a correspondence between the type of trauma, symptomatology and consequences with similar and sometimes apparently contradictory results. One of the contradictory findings suggests that young children are prone to different types of traumatic events and therefore, the severity, length of exposure and the age of the child are the predictors, rather than the nature of the trauma [25-28]. Literature has also documented many behavioral response patterns following traumatizing events. Traumatized children were found to be high on aggression towards peers [29], parents, teachers and authority figures [30]. The acting out tendencies of these adolescents may also interfere with their healthy interpersonal relationship with peer group and social interaction with others [30]. Although dissociation is a defensive reaction against stress experienced after exposure to traumatic events, it may also appear as a mechanism to suppress the emotional disturbance associated with traumatic memories. Thus, thoughts, feelings and emotions are disconnected from awareness as if they don't exist, and compensatory behaviour may become repetitive and automatic without having a complete awareness. Further, if the trauma originates in the context of a relationship with a significant person, the attachment style of that person may be severely compromised [31,32]. Literature [33] also suggests that Dissociative symptoms arise due to exposure to severe traumatic incidents in the past with which a person feels unable to cope and try to

distance himself psychologically from the stressor. Others, however, argue that dissociation may lead to the development of PTSD or other emotional symptoms by disrupting the encoding of traumatic memories and thus resulting in re-experiencing of the trauma [34]. Rana et al. [9] also state that young children with a history of a traumatic experience may present with dissociative symptoms like a trance state, amnesia, emotional and behavioral symptoms. In summary, dissociation in adolescents is closely linked with traumatic experiences in the past. Childhood trauma is a key predictor of anxiety, PTSD, dissociation and behavior problems, and PTSD symptoms can also lead to anxiety symptoms. The present study has many advantages along with some limitations also. We used structured tools to measure the outcome variables and confirmed the history and nature of trauma from family members rather than simply relying on the patient's statements. However, as with all research, the present study also comes with a number of limitations. First, the sample size was small and was taken from one Centre only, which limits the generalizability of results beyond clinical settings. Second, the interpretation of the relationship among traumatic experiences, dissociation, and externalization is given in the absence of a comparative sample. The findings should be cautiously interpreted, and longitudinal studies with clinical and non-clinical samples are warranted. Third, a distinction between different type of trauma with the age of onset was not made and actually, we weighted all traumatic experiences equally, while other research and clinical experiences show that different types of traumata and age of onset might differently affect the severity of the dissociation. Fourth, the study is retrospective, and there is no data available that describe the prior functioning of the patients before the trauma. Apart from this, the recall bias was also a limitation in this study. In spite of these limitations, we believe that the present study strengthens available findings that the short- and long-term effects of traumatic events can lead to dissociation, PTSD and behavioral problems. However, in future, researches with clear cut distinctions between the type of trauma and its onset with a comparative sample will shed more light on the impact of trauma and dissociation and will be helpful in suggesting appropriate individualized treatment programs.

### CONCLUSION

To conclude, the study shed some new light on how traumatic experiences at an early age can result in significant anxiety and behavioral problems along with the development of maladaptive defenses like dissociation. Recurrent experiences of hurt, rejection or any traumatic event can lead children to feel helpless, incapable and shattered. Therefore, they blame themselves, feel incapable of dealing with traumatic memories, and increase the possibility of developing psychiatric and behavioral disorders. History of traumatic life incidents should be ideally explored in detail psychiatric and psychological evaluation and thereafter, should be integrated into the domains of psychological interventions for adolescents diagnosed with dissociative disorders.

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