

Coping Patterns and Quality of Life in Patients with Dissociative (Conversion) Disorder: A Cross-Sectional Study Using Brief COPE and WHOQOL-BREF

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Abstract

Background: Dissociative (conversion) disorder is often accompanied by psychosocial stress, recurrent somatic presentations and disturbance in day-to-day functioning. Coping style and perceived quality of life are therefore important clinical dimensions in these patients.

Objective: To assess coping patterns and quality of life among patients diagnosed with dissociative (conversion) disorder using Brief COPE and WHOQOL-BREF.

Methods: This cross-sectional study was conducted in the Department of Psychiatry, SMS Medical College and attached hospitals, Jaipur. One hundred and ten patients fulfilling ICD-10 diagnostic criteria for dissociative (conversion) disorder were enrolled. Socio-demographic and clinical details were recorded on a structured proforma. Coping was assessed with Brief COPE, and quality of life was assessed with WHOQOL-BREF. Data were summarized using frequencies, percentages, mean and standard deviation. Group comparisons and correlation analysis were performed as appropriate, and $p < 0.05$ was considered statistically significant.

Results: Participants were predominantly female and most belonged to the young adult age group. Among coping domains, emotion-focused coping had the highest mean score (23.39 ± 3.88), followed by avoidant coping (21.89 ± 5.15) and problem-focused coping (17.41 ± 4.47). WHOQOL-BREF scores were lower across domains, with the psychological domain showing the lowest mean score (53.33 ± 8.39). Gender-wise differences in coping scores were not statistically significant. Avoidant coping did not show a significant correlation with psychological quality of life ($r = 0.01$, $p = 0.905$).

Conclusion: Patients with dissociative (conversion) disorder showed greater use of emotion-focused and avoidant coping and reduced quality of life, particularly in the psychological domain. Incorporating coping assessment and psychosocial intervention into routine management may help improve patient-centred outcomes.

Keywords: Dissociative disorder; Conversion disorder; Coping; Brief COPE; Quality of life; WHOQOL-BREF.

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Introduction

Dissociative (conversion) disorder remains a common and clinically challenging presentation in psychiatric practice. Patients may report seizure-like episodes, weakness, abnormal movements, sensory complaints or transient alteration of awareness, although the clinical picture is not explained by a primary neurological disease. Current diagnostic approaches describe dissociation as a disturbance in normally integrated functions such as memory, identity, consciousness,

perception and voluntary motor control. [1,2] Available epidemiological evidence indicates that dissociative symptoms are not rare, particularly in clinical settings. Community and hospital-based studies have reported a higher burden among adolescents, young adults and women, and this pattern has also been described in Indian samples. [3-5] In low-resource settings, social stress, family expectations, gender-based vulnerability and delayed access to psychiatric care may influence

both the presentation and persistence of symptoms. [4,5] The causation of dissociative symptoms is usually not explained by a single factor. Trauma, interpersonal conflict, chronic stress and maladaptive psychological responses have all been implicated. [6,7] Neurobiological work also suggests altered functioning of networks involved in emotional regulation, self-referential processing and executive control. [8] Clinically, however, the way patients manage stress in daily life is often more directly relevant for treatment planning.

Coping refers to the cognitive and behavioural efforts used by a person to deal with stressful internal or external demands. [9] The Brief COPE scale provides a practical method for assessing coping responses and commonly groups them into problem-focused, emotion-focused and avoidant coping. [10] Problem-focused coping reflects attempts to solve or modify the stressor, while emotion-focused coping mainly regulates distress. Avoidant coping includes denial, disengagement, self-blame or other responses that reduce immediate distress without addressing the underlying problem. [11,13]

In patients with dissociative symptoms, coping style may be particularly relevant because psychological distress is often expressed through bodily or altered-awareness symptoms. Avoidant coping can maintain the cycle of stress, symptom expression and functional limitation, whereas active coping and better emotional regulation may support recovery. [11,14] Assessing coping can therefore identify modifiable targets for psychoeducation and psychotherapy.

Quality of life is another essential outcome in dissociative disorder. The WHOQOL-BREF assesses subjective well-being across physical, psychological, social and environmental domains and has been widely used in psychiatric research. [15,16] Patients with dissociative or functional neurological symptoms often experience poor psychological well-being, reduced functioning, stigma and recurrent healthcare contact. [17-20]

Coping and quality of life are linked concepts. Adaptive coping has generally been associated with better psychological adjustment, while avoidant coping has been associated with distress and poorer health-related outcomes. [12,21-23] In India, cultural ideas about emotional expression, family responsibility, stigma and help-seeking may further shape coping behaviour and perceived quality of life. [24-26]

Although dissociative disorder has been studied in relation to stressors, clinical profile and family factors, fewer Indian studies have examined coping patterns and quality of life together using Brief COPE and WHOQOL-BREF. [27] The present

study was therefore undertaken at SMS Medical College, Jaipur, to describe coping patterns and quality of life among patients with dissociative (conversion) disorder and to explore the relationship between coping style and psychological quality of life.

Methodology

This hospital-based cross-sectional observational study was carried out in the Department of Psychiatry, SMS Medical College and attached hospitals, Jaipur, over a period of one year from September 2024 to August 2025. The study focused on patients diagnosed with dissociative (conversion) disorder and assessed their coping patterns and quality of life.

Patients attending the psychiatric outpatient department or admitted to inpatient psychiatric services during the study period were screened for eligibility. A total of 110 patients who fulfilled ICD-10 criteria for dissociative (conversion) disorder were included. The diagnosis was confirmed by qualified psychiatrists before enrolment.

Patients aged 15-50 years, of either sex, who provided written informed consent were included. Patients with coexisting neurological illness, severe cognitive impairment, major psychiatric comorbidity or substance dependence other than nicotine were excluded so that the assessment of coping and quality of life was not substantially confounded by these conditions.

Eligible participants were enrolled consecutively by convenience sampling. After consent, socio-demographic details, relevant clinical history, illness duration and current psychotropic medication use were recorded using a structured proforma.

Coping patterns were assessed using the Brief Coping Orientation to Problems Experienced (Brief COPE) inventory. It is a 28-item self-report scale that assesses commonly used coping responses. For analysis, coping was summarized under problem-focused, emotion-focused and avoidant domains. Quality of life was assessed using WHOQOL-BREF, which measures physical health, psychological health, social relationships and environmental health, along with overall quality of life and general health perception. Both scales were administered in a single sitting under supervision. Any item-related doubt was clarified without leading the response, and forms were checked for completeness at the time of collection.

Data were entered in Microsoft Excel and analyzed using SPSS software. Categorical variables were expressed as frequencies and percentages. Continuous variables were expressed as mean and

standard deviation. Gender-wise comparison of coping scores was performed using an appropriate test for independent groups. The relationship between avoidant coping and psychological quality of life was examined using correlation analysis. A p-value less than 0.05 was considered statistically significant.

Institutional Ethics Committee approval was obtained before data collection. Participants were informed about the purpose of the study, voluntary participation and confidentiality of information.

Results

A total of 110 patients with dissociative (conversion) disorder were included. The largest age group was 21-30 years (34.5%), followed by 31-40 years (26.4%). Patients aged 20 years or less constituted 21.8%, while 17.3% were in the 41-50 years group. Females formed 72.7% of the sample. Rural residence was reported by 60.0% of participants. Regarding marital status, 45.5% were single and 40.9% were married (Table 1).

Table 1: Socio-demographic characteristics of participants

Variable	Category	n (%)
Age (years)	<=20	24 (21.8)
	21-30	38 (34.5)
	31-40	29 (26.4)
	41-50	19 (17.3)
Gender	Male	30 (27.3)
	Female	80 (72.7)
Residence	Urban	44 (40.0)
	Rural	66 (60.0)
Marital status	Single	50 (45.5)
	Married	45 (40.9)
	Divorced	11 (10.0)
	Widowed	4 (3.6)

Educational distribution showed that secondary education was the most frequent category (37.3%), followed by graduate or postgraduate education (24.5%). Students constituted the largest occupational group (42.7%), followed by homemakers (21.8%). Most patients had an illness duration of 6 months or less (60.9%), and 35.5% were receiving psychotropic medication at the time of assessment (Table 2).

Table 2: Educational, occupational and clinical profile

Variable	Category	n (%)
Education	Illiterate	9 (8.2)
	Below primary	14 (12.7)
	Matric	19 (17.3)
	Secondary	41 (37.3)
	Graduate/Postgraduate	27 (24.5)
Occupation	Unemployed	14 (12.7)
	Employed	17 (15.5)
	Student	47 (42.7)
	Homemaker	24 (21.8)
	Labourer	8 (7.3)
Duration of illness	<=6 months	67 (60.9)
	7-12 months	28 (25.5)
	>12 months	15 (13.6)
Psychotropic use	Yes	39 (35.5)
	No	71 (64.5)

On Brief COPE assessment, the highest mean score was observed for emotion-focused coping (23.39 ± 3.88), followed by avoidant coping (21.89 ± 5.15). Problem-focused coping had the lowest mean score (17.41 ± 4.47) (Table 3 and Figure 1).

Table 3: Coping patterns based on Brief COPE scores

Coping domain	Mean $\pm$ SD
Problem-focused coping	17.41 ± 4.47
Emotion-focused coping	23.39 ± 3.88
Avoidant coping	21.89 ± 5.15

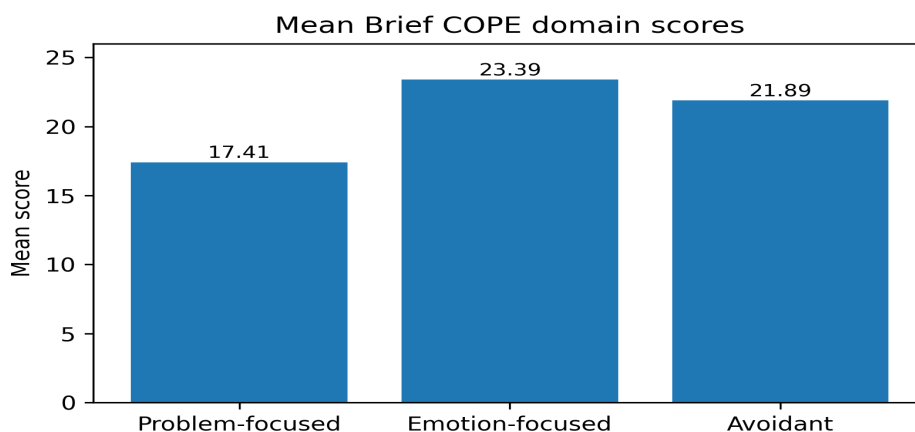


Figure 1: Mean scores of problem-focused, emotion-focused and avoidant coping

Gender-wise comparison showed that females had slightly higher emotion-focused and avoidant coping scores, whereas males had a slightly higher problem-focused coping score. These differences were statistically non-significant for all three domains (Table 4).

Table 4: Gender-wise comparison of coping patterns

Coping domain	Male (Mean $\pm$ SD)	Female (Mean $\pm$ SD)	p-value
Problem-focused	18.02 $\pm$ 4.36	17.15 $\pm$ 4.52	0.350
Emotion-focused	22.91 $\pm$ 3.94	23.59 $\pm$ 3.85	0.404
Avoidant	20.74 $\pm$ 4.91	22.35 $\pm$ 5.21	0.142

Test applied: independent-samples comparison; $p < 0.05$ was considered statistically significant.

WHOQOL-BREF assessment showed that the psychological health domain had the lowest mean score (53.33 ± 8.39), followed by physical health (54.49 ± 7.25). Social relationships and environmental domains had mean scores of 56.50 ± 9.36 and 56.23 ± 9.22 , respectively (Table 5 and Figure 2).

Table 5: Quality of life based on WHOQOL-BREF domain scores

Domain	Mean $\pm$ SD
Physical health	54.49 $\pm$ 7.25
Psychological health	53.33 $\pm$ 8.39
Social relationships	56.50 $\pm$ 9.36
Environmental	56.23 $\pm$ 9.22

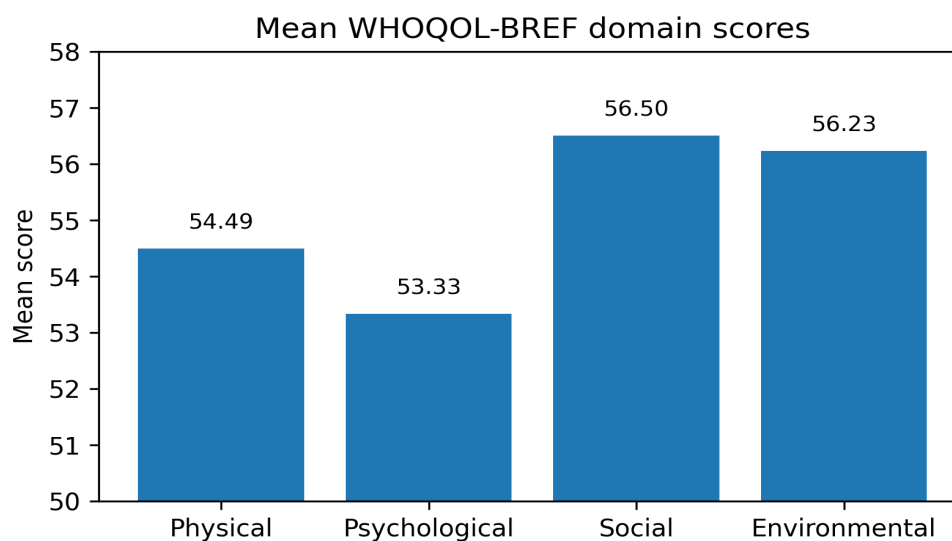


Figure 2: Mean WHOQOL-BREF domain scores among patients

The mean overall quality of life score was 3.11 ± 0.84 , while the mean general health perception score was 3.06 ± 0.79 (Table 6).

Table 6: Overall quality of life and general health perception

Variable	Mean $\pm$ SD
Overall QOL	3.11 ± 0.84
General health perception	3.06 ± 0.79

Correlation analysis showed no statistically significant relationship between avoidant coping and psychological quality of life ($r = 0.01$, $p = 0.905$). The scatter plot showed wide dispersion of values around an almost horizontal trend line (Figure 3).

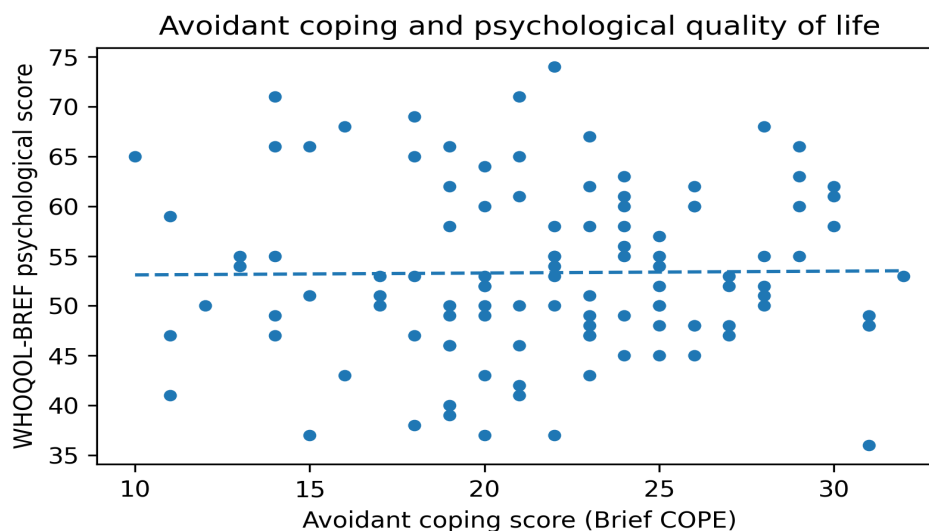


Figure 3: Scatter plot showing relationship between avoidant coping and psychological quality of life

Discussion

This study examined coping patterns and quality of life among 110 patients with dissociative (conversion) disorder. The main findings were greater use of emotion-focused and avoidant coping compared with problem-focused coping, reduced WHOQOL-BREF scores across domains, and the lowest quality-of-life score in the psychological domain. Gender-wise differences in coping were not statistically significant, and avoidant coping did not show a significant correlation with psychological quality of life.

The socio-demographic profile showed predominance of young adults and females. This pattern is similar to Indian clinical observations reported by Dutta et al., in which dissociative disorders were more frequently seen among younger patients and women.⁵ International reviews also describe higher dissociative symptom burden in clinical populations and emphasize the contribution of social stress and trauma-related vulnerability. [3,4] The present findings may reflect the combined influence of age-specific stressors, gender roles and help-seeking patterns in the local population. The most important psychological finding was the higher score for emotion-focused

coping, followed closely by avoidant coping. Lazarus and Folkman described coping as an active process through which individuals appraise and respond to stress. [9] Carver's Brief COPE provides a compact way to examine these responses in clinical groups. [10] In the present sample, lower problem-focused coping suggests that many patients were less likely to use direct problem solving or planning while dealing with distress.

The greater use of avoidant coping is clinically meaningful in dissociative disorder. Holahan et al. found that avoidance coping was associated with later depressive symptoms, while Compas et al. reviewed evidence linking coping patterns with psychological adjustment during development. [13,22] In dissociative presentations, avoidance may reduce distress temporarily but can maintain symptoms by preventing emotional processing and practical resolution of stressors. This interpretation is also consistent with trauma-based and dissociation models described by Sar et al. and Brand et al. [6,14]

Gender-wise coping differences were not statistically significant. Although females had numerically higher emotion-focused and avoidant

scores, the differences were small and may not represent a true group-level distinction. Taylor and Stanton noted that coping is shaped not only by gender but also by coping resources, context, perceived control and psychological demands. [23] Therefore, in this sample, the clinical condition and psychosocial situation may have been more important than sex alone in shaping coping responses.

Quality-of-life assessment showed lower scores across all WHOQOL-BREF domains, with the psychological domain being the most affected. WHOQOL-BREF evaluates the patient's own perception of physical health, psychological health, social relationships and environment. [15,16] The lower psychological score in the present study is consistent with previous work on dissociative seizures and functional neurological disorders, where emotional distress, stigma, disability and psychiatric comorbidity have been shown to reduce quality of life. [17-20]

The physical domain was also reduced, which may be related to fatigue, somatic symptoms, restrictions in daily activity and repeated illness episodes. The social and environmental domains were slightly higher than the psychological domain but remained modest. In Indian settings, family support may buffer some social difficulties, yet stigma, financial strain and limited mental health literacy can continue to affect well-being. Kirmayer and Raguram et al. have emphasized the relevance of cultural context in symptom expression and help-seeking in South Asian populations. [24,25]

The non-significant correlation between avoidant coping and psychological quality of life should be interpreted cautiously. Studies by Folkman and Moskowitz and Penley et al. have shown that coping is related to psychological and health outcomes, but the strength of association depends on the population, stressor type, measurement method and time frame. [12,21] The lack of significance in the present study may be due to cross-sectional measurement, limited sample size, or the presence of unmeasured mediators such as illness severity, family conflict, personality traits, trauma history and ongoing treatment.

Clinically, the findings support the need to look beyond symptom control in dissociative disorder. Routine assessment of coping and quality of life may help clinicians identify patients who require psychoeducation, stress management, family intervention or structured psychotherapy. Interventions that reduce avoidance, strengthen problem-focused coping and improve emotional regulation may be useful adjuncts to usual psychiatric care. Contemporary reviews of dissociation also support integrative approaches that address cognitive, emotional and behavioural

processes. [29,30] Overall, the study adds local evidence that dissociative (conversion) disorder is associated with a coping profile dominated by emotion-focused and avoidant responses and with reduced quality of life, especially psychological well-being. These findings are relevant for planning culturally sensitive psychosocial interventions in routine psychiatric services.

Limitations

This study had certain limitations. The cross-sectional design did not allow causal conclusions about the relationship between coping and quality of life. The hospital-based convenience sample may not represent all patients with dissociative disorder in the community. Self-reported scales may be affected by recall bias, response style or social desirability. A control group was not included. Important variables such as trauma severity, family functioning, personality traits and longitudinal treatment response were not assessed in detail.

Conclusion

Patients with dissociative (conversion) disorder in this study showed higher use of emotion-focused and avoidant coping than problem-focused coping. Quality of life was reduced across WHOQOL-BREF domains, with the psychological domain showing the lowest score. Gender-wise differences in coping were not statistically significant, and avoidant coping was not significantly correlated with psychological quality of life. These findings highlight the importance of assessing coping and quality of life as part of a comprehensive biopsychosocial approach.

Recommendations

Psychiatric assessment of patients with dissociative disorder should include evaluation of coping style and quality of life. Psychoeducation, stress management, family-based support and therapies aimed at reducing avoidant coping and improving problem-focused coping may be incorporated into routine care. Future studies should use larger samples, longitudinal designs, comparison groups and detailed assessment of psychosocial stressors to better clarify how coping influences quality of life and treatment outcome.

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