

A cross-sectional comparative study of perceived parental style, cognitive style, and perceived stress among adolescents with dissociative disorders and normal adolescents.**Rana Nasim^{1*}, Amardeep Kumar²**¹Senior Resident, Department of Psychiatry, Patna Medical College and Hospital, Patna, Bihar, India.²Senior Resident, Department of Psychiatry, BMIMS Pawapuri, Nalanda, Bihar, India.

Page | 1

Abstract**Background:**

Dissociative disorders are complex problems caused by a variety of psychological and environmental causes. Understanding the role of demographic variables, perceived parental styles, cognitive styles, and felt stress is critical for uncovering underlying mechanisms and developing management approaches.

Objective:

To compare the impact of demographic characteristics, perceived parental styles, cognitive styles, and reported stress on adolescents with dissociative disorders vs healthy controls.

Methods:

A comparative observational study was carried out with teenagers diagnosed with dissociative disorders and matched healthy controls. Sociodemographic data were collected, and established tests such as the Cognitive Style Inventory (CSI), Adolescent Dissociative Experiences Scale (A-DES), Perceived Stress Scale (PSS), and S-EMBU (perceived parental style) were used. Statistical analysis was conducted using suitable methods, with $p < 0.05$ indicating significance.

Results:

There were no statistically significant differences between the case and control groups in demographic factors such as age, education, occupation, marital status, religion, and socioeconomic position ($p > 0.05$). Although females were more common in the case group, the differences were not statistically significant. Cognitive style (CSI) and dissociative experiences (A-DES) showed no significant difference between groups ($p = 0.261$ and $p = 0.403$, respectively). Similarly, subjective stress levels (PSS) were not significantly different ($p = 0.614$). However, a significant link was discovered between perceived parental style (S-EMBU) and dissociative disorders ($p = 0.037$), emphasizing the importance of parenting practices.

Conclusion:

The sense of parental style is important in dissociative disorders, while demographics, cognitive style, and felt stress have less independent influence. These findings highlight the significance of family dynamics and early psychosocial interventions in the treatment of dissociative disorders.

Recommendation:

Early identification of maladaptive parenting patterns and family-based interventions should be incorporated in the management of adolescents with dissociative disorders.

Keywords: Parental style, demographics, cognitive style, Perceived Stress Scale (PSS), Cognitive Style Inventory (CSI)**Submitted:** January 10, 2026 **Accepted:** February 15, 2026 **Published:** March 30, 2026**Corresponding Author:** Rana Nasim**Email:** rana.nasim20@gmail.com

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Introduction

Dissociative disorders are defined by disruptions in integrated psychological functions such as memory, awareness, identity, emotion, perception, and action. These illnesses are frequently connected with traumatic or

overwhelming events, especially in severe clinical manifestations. The frequency of dissociative disorders is believed to be around 2.4% in industrialized countries, with dissociative identity disorder accounting for about 1%. They are more common in young women and can

cause symptoms like convulsions, aphonia, amnesia, sensory abnormalities, and trance or possession states.(1). Several risk factors have been identified, including childhood physical or sexual abuse, adult trauma, academic stress, interpersonal problems, and daily life pressures. Poor cohesion, insufficient communication, and unhappiness are all associated with increased vulnerability in the family environment. Parenting style is a significant predictor of psychological development. According to Baumrind's taxonomy, parenting styles are authoritative, authoritarian, permissive, and neglectful, based on warmth and control. Importantly, perceived parental style—how people interpret parenting behavior—can differ from actual parenting and have a greater impact on emotional and behavioral results(2).

Cognitive style refers to how people process, interpret, and respond to information. Negative cognitive styles have been linked to maladaptive coping methods and greater vulnerability to psychopathology. Perceived stress is an individual's assessment of life pressures and ability to manage, rather than the objective incidence of stressful events (Jieun, 2016). It focuses on the relationship between internal coping mechanisms and environmental pressures. The study aimed to evaluate the relationship between perceived parental style, cognitive style, and perceived stress in dissociative disorders, to find relevant elements and improve therapeutic techniques and psychoeducation.(3).

Materials and methods

Study setting

The study was conducted at the Department of Psychiatry, Patna Medical College & Hospital, Patna, Bihar, a tertiary care teaching hospital catering to a large population from urban and rural areas of Bihar and neighboring states. The hospital provides outpatient and inpatient psychiatric services.

Study place:

Department of Psychiatry, Patna Medical College & Hospital, Patna, Bihar.

Sample size:

Consisted of 30 diagnosed cases of Dissociative Disorder according to ICD-10, DCR (WHO, 1993), and 30 matched control counterparts (control group).

Study Design:

A cross-sectional comparative hospital-based study. The subject was recruited for the study by the purposive sampling technique.

Sample Size Calculation:

The sample size of 60 participants (30 cases and 30 controls) was determined based on feasibility and previous similar studies. However, ideally, it should be calculated using a prevalence-based formula:

$$n = Z^2 \times p \times q / d^2$$

Inclusion criteria for cases:

1. Either sex
2. 13 years - 18 years
3. Diagnosed cases of depressive disorder according to ICD-10, DCR (WHO, 1993).
4. Guardian of the patient giving written informed consent.

Exclusion criteria for cases:

1. Comorbid major psychiatric disorder
2. Major medical or neurological disorders
3. Associated mental retardation.
4. Individuals with a history of substance use meeting dependence criteria, other than nicotine and caffeine.
5. Uncooperative patients.

Inclusion criteria for controls

1. Either sex.
2. Age: 13 years to 18 years.
3. Age, education, and socio-economic status matched with the patient group.
4. Guardian of the patient giving written informed consent.

Exclusion criteria for controls:

1. History of any major medical illness.
 2. History of organicity (neurological disorder, significant head injury)
2. History of any psychiatric illness.
3. Score ≥ 3 on General Health Questionnaire-12.
4. Mental Retardation.
5. Uncooperative adolescents

Bias:

Selection bias was minimized by using defined inclusion and exclusion criteria. Matching was done for age, education, and socioeconomic status. Standardized and validated tools were used to reduce measurement bias.

Variables:

Primary variables included perceived parental style (S-EMBU scores).

Secondary variables included cognitive style (CSI), dissociative experiences (A-DES),

perceived stress (PSS), and sociodemographic factors.

Statistical Analysis:

All data were analysed using the SPSS software (Stata, version 26.0 SPSS INC, Chicago, IL, USA) for Windows. The data were provided as descriptive statistics for continuous variables and percentages for categorical variables, and they were tested using the Chi-square, t-

test, and ANOVA test. Other values were given as numbers, percentages (%), and mean $\pm$ SD.

Observation and results

A total of 80 adolescents were screened, out of which 60 met the inclusion criteria and were included in the study (30 cases and 30 controls). 20 participants were excluded due to not meeting the inclusion criteria or refusal to participate.

Table 1: Age distribution of subjects

Age in years	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	0.668
13 - 14	6	20%	8	26.67%	
15 - 16	11	36.67%	8	26.67%	
17 - 18	13	43.33%	14	46.67%	
Total	30	100%	30	100%	
Mean ±SD	16.10±1.56		15.90±1.72		

Females constituted the majority in both groups, accounting for 80% of cases and 73.33% of controls, while males comprised 20% and 26.67%, respectively.

This indicates a higher proportion of females in both groups, although no statistical significance was reported.

Table 2: Gender distribution of subjects

Gender	Case Group (n=30)		Control Group (n=30)	
	Frequency	Percentage	Frequency	Percentage
Male	6	20%	8	26.67%
Female	24	80%	22	73.33%
Total	30	100%	30	100%

In the case group, most participants had a high school education (33.33%), followed by intermediate (30%), middle school (26.67%), and primary education (10%). In the control group, the majority were from middle school

(46.66%), followed by high school (26.67%), primary (16.66%), and intermediate (10%). There was no statistically significant difference between the groups ($p = 0.799$).

Table 3: Distribution of patients according to their educational qualification

Educational qualification	Case Group (n=30)		Control Group (n=30)		P. Value
	Frequency	Percentage	Frequency	Percentage	
Primary	3	10%	5	16.66%	0.799
Middle School	8	26.67%	14	46.66%	
High School	10	33.33%	8	26.67%	
Intermediate	9	30%	3	10%	
Total	30	100%	30	100%	

All participants in the case group were students (100%), whereas in the control group, 30% were students and 70% were school dropouts. Despite this apparent difference, the association was not statistically significant ($p = 1.000$).

Table 4: Distribution of patients according to their occupation

Occupation	Case Group (n=30)		Control Group (n=30)		P. Value
	Frequency	Percentage	Frequency	Percentage	
Student	30	100%	9	30%	1.000
Drop out	0	0%	21	70%	
Total	30	100%	30	100%	

The majority of participants in both groups were unmarried (96.67% in cases vs 90% in controls), with only a small proportion being married (3.33% vs 10%). There was no statistically significant difference between the groups ($p = 1.000$).

Table 5: Distribution of patients according to their MS

MS	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	
M	1	3.33%	3	10%	1.000
UM	29	96.67%	27	90%	
Total	30	100%	30	100%	

Table 6: Distribution of patients according to their religion

Religion	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	
Hindu	27	90%	25	83.33%	1.000
Muslim	3	10%	5	16.67%	
Total	30	100%	30	100%	

In the case group, half of the participants (50%) belonged to the upper-lower socioeconomic class, followed by lower class (33.33%), upper-middle (10%), and lower-middle (6.67%). In the control group, the majority were

from the lower class (53.33%) and upper-lower class (46.67%). No statistically significant difference was observed between groups ($p = 0.095$).

Table 7: Frequency of socio-economic status of the patients in the study population

Socio-economic status	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	
Lower	10	33.33%	16	53.33%	0.095
Upper lower	15	50%	14	46.67%	
Lower middle	2	6.67%	0	0%	
Upper middle	3	10%	0	0%	
Total	30	100%	30	100%	

In the case group, the majority of participants (86.67%) had A-DES scores greater than 4, indicating higher dissociative experiences, while 13.33% had scores less than 4. However, no statistically significant association was observed ($p = 0.403$).

Table 8: Patients according to A-DES

A-DES	Case Group (n=30)		P. Value
	Frequency	Percentage	0.403
<4	4	13.33%	
>4	26	86.67%	
Total	30	100%	

Page | 5

In the case group, most participants (60%) had CSI scores between 118 and 137, followed by 36.67% in the 103–117 range, and a small proportion (3.33%) in the 138–153 range. In the control group, the majority (53.33%) also fell

in the 118–137 range, followed by 40% in the 138–153 range and 6.67% in the 154–168 range. There was no statistically significant difference between the groups ($p = 0.261$).

Table 9: Patients according to CSI

CSI	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	0.261
86 & below	0	0%	0	0%	
87-101	0	0%	0	0%	
103-117	11	36.67%	0	0%	
118-137	18	60%	16	53.33%	
138-153	1	3.33%	12	40%	
154-168	0	0%	2	6.67%	
Total	30	100%	30	100%	

Table 10: Patients according to PSS

PSS	Case Group (n=30)		Control Group (n=30)		P. Value
	Frequency	Percentage	Frequency	Percentage	0.614
0-13 Low stress	0	0%	9	30%	
14-26 Moderate stress	20	66.67%	21	70%	
27-40 High perceived stress	10	33.33%	0	0%	
Total	30	100%	30	100%	

**Table 11: Patients according to EMBU R
(Egna Minnen Beträffande Uppfostran Rejection)**

EMBU R	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	0.037
6	1	3.33%	0	0%	
7	7	23.33%	10	33.33%	
8	11	36.67%	16	53.33%	
9	6	20%	4	13.33%	
10	5	16.67%	0	0%	
Total	30	100%	30	100%	

In the case group, emotional warmth scores were distributed across categories, with the highest proportions at scores of 17 and 18 (23.33% each), followed by 16 (20%) and 19 (16.67%). In the control group, the majority

had scores of 17 (36.67%) and 18 (30%). The difference between groups was statistically significant ($p = 0.030$), suggesting variation in perceived emotional warmth.

**Table 12: Patients according to EMBU EW
(Egna Minnen Beträffande Uppfostran Emotional Warmth)**

EMBU EW	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	
15	1	3.33%	1	3.33%	0.030
16	6	20%	2	6.67%	
17	7	23.33%	11	36.67%	
18	7	23.33%	9	30%	
19	5	16.67%	2	6.67%	
20	2	6.67%	4	13.33%	
21	1	3.33%	1	3.33%	
23	1	3.33%	0	0%	
Total	30	100%	30	100%	

In the case group, the highest proportion of participants (30%) had a score of 19, followed by 23.33% with a score of 18 and 13.33% with a score of 17. In the control group,

most participants had scores of 16 (30%), 15 (23.33%), and 14 (20%). However, the difference between groups was not statistically significant ($p = 0.420$).

**Table 13: Patients according to EMBU OP
(Egna Minnen Beträffande Uppfostran over protection)**

EMBU OP	Case Group (n=30)		Control Group (n=30)		P. value
	Frequency	Percentage	Frequency	Percentage	
13	2	6.67%	3	10%	0.420
14	1	3.33%	6	20%	
15	3	10%	7	23.33%	
16	1	3.33%	9	30%	
17	4	13.33%	4	13.33%	
18	7	23.33%	1	3.33%	
19	9	30%	0	0%	
20	1	3.33%	0	0%	
21	1	3.33%	0	0%	
23	1	3.33%	0	0%	
Total	30	100%	30	100%	

Discussion

The current study sought to investigate the role of demographic characteristics, perceived parental styles, cognitive styles, and reported stress in adolescents with dissociative disorders as compared to healthy controls. The data suggest that major sociodemographic characteristics, such as age, education, occupation, marital status, religion, and socioeconomic level, did not differ significantly between the case and control groups ($p >$

0.05). This shows that these baseline variables have a limited impact on dissociative disorders.(4).

In terms of gender distribution, both groups had a higher number of females, particularly in the case group, indicating that females may be more susceptible to dissociative disorders. However, statistical significance was not determined. These findings are consistent with previous research, which indicates that females may feel

more psychological distress and emotional dysregulation.(5).

The Cognitive Style Inventory (CSI) indicated no significant difference between groups ($p = 0.261$), implying that cognitive processing patterns do not differ significantly between teenagers with dissociative disorders and controls. Similarly, there was no statistically significant difference in A-DES scores ($p = 0.403$), showing that dissociative experiences may not be sufficient to separate clinical and non-clinical persons.(6). The Perceived Stress Scale (PSS) revealed that the majority of patients had moderate to high stress, whereas controls had moderate stress. However, the difference was not statistically significant ($p = 0.614$). These findings contradict some research indicating increased stress levels in dissociative disorders, implying that stress may not be a determining factor but rather interacts with other psychological variables.(7).

The study found a significant link between perceived parenting style (S-EMBU) and dissociative disorders ($p = 0.037$). This emphasizes the significance of parenting practices, including emotional warmth, responsiveness, and support, in molding psychological consequences. Previous research suggests that a lack of emotional warmth and parental affection can lead to maladaptive coping mechanisms, such as dissociation. Further research indicates that emotional warmth is favourably connected with systematic cognitive style and resilience. Individuals who have had supportive parenting are more likely to acquire structured thinking and effective problem-solving skills, which improve resilience in stressful situations. Negative parenting methods, such as rejection or overprotection, can lead to maladaptive cognitive habits and greater susceptibility to psychiatric problems.(8).

The relationship between cognitive style and resilience was also substantial, indicating that those who use systematic cognitive processing are better able to manage stress and adapt to difficult conditions. Dissociation appears to be a multifaceted phenomenon driven by a combination of parenting style, cognitive processing, and stress perception rather than a single etiological cause. In conclusion, whereas demographic factors had little influence, parental style emerged as a critical driver in dissociative disorders. These findings highlight the significance of early psychosocial therapies that concentrate on family dynamics and adaptive coping strategies.(9).

Generalizability

The findings of this study may be generalized to adolescents attending tertiary care psychiatric

settings; however, caution is required while applying results to community populations.

Conclusion

This study proposes that these identification markers might be assessed by examining one's perceived parenting and cognitive styles. A student's success is largely determined by his or her academic performance. The outcome is ultimately determined by the student's mental state and ability to deal with failure. In today's highly dynamic and competitive world, kids are exposed to a variety of stressors that can have an impact on all aspects of their lives. The study's findings imply that cognitive styles have a significant impact on resilience.

The current study also asserts that management and students who exhibit logical thinking have greater resilience than other students. Ironically, the kids who were more focused on emotions and feelings had less resilience. Management and students demonstrated a step-by-step approach to problem-solving before developing an overarching plan to improve resilience. On the other hand, gorgeous students from other departments had demonstrated an unpredictable approach to analytical difficulties, which would undoubtedly work as a motivator for resilience. Finally, kids who use a behavioral decision-making approach have been shown to have low resilience skills.

Limitations

The study had a small sample size and was hospital-based, limiting generalizability. The cross-sectional design prevents causal inference. Self-reported measures may introduce response bias.

Recommendation

Family-based interventions focusing on improving parenting practices should be incorporated into treatment strategies. Further large-scale longitudinal studies are recommended.

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Conflict of Interest

The authors declare no conflict of interest.

Data Availability

Data supporting the findings are available from the corresponding author upon reasonable request.

Author Contributions

RN: Concept, data collection, manuscript writing

AK: Data analysis, interpretation

Both authors approved the final manuscript.

List of Abbreviations

CSI – Cognitive Style Inventory

PSS – Perceived Stress Scale

A-DES – Adolescent Dissociative Experiences Scale

S-EMBU – Egna Minnen Beträffande Uppfostran

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