Psychopatological severity index and dissociative symptomatology in a group of non-psychotic outpatients

Indici di gravità psicopatologica e sintomatologia dissociativa in una popolazione di pazienti ambulatoriali non psicotici

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Summary

Dissociative symptoms are a set of symptoms frequently encountered in clinical practice, but they are often underestimated by many clinicians, who in the routine assessment of the patient underrate or not diagnose, emphasizing instead the importance of more classic and obvious symptoms, such as those related to the sphere of mood, anxiety or psychosis. In this way, dissociative symptoms often lose their descriptive complexity, although purely psychopathological, of the very complex clinical status that often underlie dissociative symptoms and dissociative dynamics. For these reasons, this study assessed psychopathological dimensions of mood and anxiety disorders in a transnosographic way. The purpose of the study is to demonstrate that dissociative symptoms, although placed in the diagnostic category of dissociative disorders, have a common thread that correlates with the main manifestations detected in routine clinical practice, and that they may be susceptible to intervention by the physician, even in a nonspecific way on the main symptom, not dissociative, that is treated.

Key words

Dissociative disorders • Dissociation • Anxiety • Depression • Bipolar disorder • Obsessive-compulsive disorder • Stress

The diagnosis of dissociative disorders, as a group of categorical independent nosographic entities, was first included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-III in 1980; before that, dissociative symptomatology was included among psychopathological phenomena ascribed to hysteria [1]. The essential characteristic of dissociative disorders, according to the DSM-IV-TR, is the disconnection of functions (physiologically integrated), of consciousness, memory and perception of identity [2]. The term dissociative was introduced by James in 1890 as a translation of the French term *désagrégation* coined by Pierre Janet in 1889; with this term, the French author individuated the failure of mental integration of 'experiences' (perceptions, memories, thoughts, emotions) that are normally concatenated with each other in the flow of consciousness[1]. Dissociation leads to fragmentation of the unitary sense of self in patients who experience it, cancelling the unity of chronological, biographical and perceptual identity, which every individual normally has [3]. In studies on hysteria (1893-1895), Freud elaborated a psychodynamic theory of dissociation (opposed to the psychopathological one of Janet, linked to passive ego deficits) based on active removal, in affected subjects, of traumatic material within a psychodynamic conflict. In both models, dissociation appears to be closely related to the presence of a traumatic event [1]. Recent studies have shown that the post-traumatic aetiological aspect of dissociative episodes identifies a part of dissociative symptomatology (about 50%), but not the entire dissociative spectrum [4]. The dissociative spectrum (Fig. 1) is composed of a large continuum of dissociative symptomatology along a gradient of severity [1].

Such a spectrum even includes, according to some authors, somatoform disorders and can be divided into three groups:

- *non-clinical or subclinical dissociative experiences*, such as being so deeply assorbed in the contemplation of a movie or immersed in one's own thoughts,that there is no awareness or realization of the surrounding environment (absorption);
- *transient dissociative phenomena in response to external events (trauma, induced states of trance);*
- *clinically-relevant dissociative phenomena*, either in association with other psychiatric disturbances (e.g.

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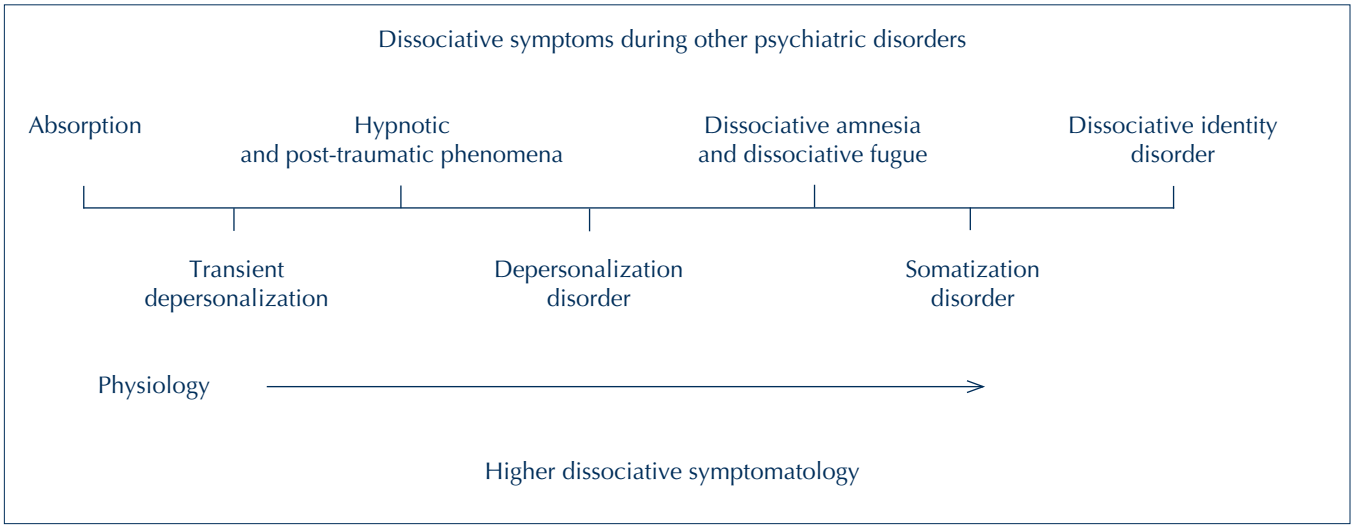

FIGURE 1.
Continuum of dissociative symptomatology and related dissociative disorders. *Continuum della sintomatologia dissociativa e relativi disturbi dissociativi.*

PTSD), or as a defined nosographic category (depersonalization disorder, dissociative amnesia, dissociative fugue, dissociative identity disorder and dissociative disorder not otherwise specified).

According to some authors, the prevalence of dissociative disorders in clinical practice is underestimated, which may be in part due to the lack of inclusion of diagnostic criteria for dissociative disorders in the algorithm of the Structured Clinical Interview for the diagnosis of Axis I disorders in the DSM-IV (SCID-I), as well as the lack of large population-based studies [3]; at present, the prevalence of dissociative disorders in the general population is estimated to be from 5.6% to 10% [1].
At the same time, there is some evidence regarding the association of dissociative symptoms with some psychopathological dimensions, (in particular with obsessions [5], depression and anxiety [6], psychotic symptoms [7 8] and with the severity of a psychiatric disorders [5]). Moreover, it has been observed that patients affected with dissociative disorders have levels of psychopathology (assessed with SCL90-R) that are significantly greater than those in psychiatric patients who are non-dissociators[10]. Considering this, the aim of the present study was to investigate the relation between dissociative symptomatology, psychopathological dimensions (assessed with SCL90-R) and clinical severity in an out-patient population.

Materials and methods

Over an 18-month period, a total of 83 patients (of 213 contacted) were recruited among those presenting to the out-patient psychopharmacological clinic at Policlinico Umberto I, during the first visit. Inclusion criteria included: diagnosis of anxiety, mood and somatoform disorder and adaptation; score > 17 on at least one of the Hamilton scales (A or D). Exclusion criteria were: psychotic disorder, illiteracy, unable to understand questionnaires, presence of a neurodegenerative disease, concomitant diagnosis of epilepsy or on-going problem with addiction.
The study protocol included the administration of a questionnaire for personal data, authorization to keep sensitive data, evaluation scales completed by a clinician (*Clinical Global Impression* [CGI], *Hamilton Anxiety Rating Scale* [HAM-A], *Hamilton Depression Rating Scale* [HAM-D]); self-evaluation questionnaires relative to general psychiatric symptoms (*Symptom Checklist-90-Revised-SCL90-R*) and dissociative symptomatology (*Dissociative Experiences Scale* [DES]).
The CGI evaluates general clinical severity of the patient using a scale from 0 to 7 (0 = Not assessed 1 = Normal, not at all ill, 2 = Borderline mentally ill, 3 = Mildly ill, 4 = Moderately ill, 5 = Markedly ill, 6 = Severely ill, 7 = Among the most extremely ill patients); the two Hamilton scales evaluate anxiety symptoms (score ≥18 considered pathological) and depression (score ≥ 25 = severe depression; 18-24 = moderate depression; 8-17 = slight depression; ≤ 7 absence of depression).
The SCL 90-R assesses 9 psychopathological dimensions (*somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation, psychoticism*), and on the basis of the total score considering 90 *items*, the *Global Severity Index* (GSI) can be calculated; a value greater than 0.566 is con-

sidered indicative of clinically-relevant psychopathology. Using the DES, dissociative symptomatology was evaluated dimensionally and transnosographically. The DES is a self-rating scale that measures the level and type of dissociative experience present (the period of evaluation is lifelong, in general) without considering the diagnosis; it is quick to compile and is composed of 30 questions that consider a score from 0 to 100 in intervals of 10; overall mean global scores higher than 20 are indicative for the presence of a dissociative disturbance [9]. Through a diagnostic interview, for each patient, a diagnosis was formulated based on the criteria in the DSM IV-TR [2].

The SPSS 13 programme was used for statistical analysis, and the distribution of variance was analyzed using the Kolmogorov-Smirnov test. Based on the results of the quantitative distribution of variables (e.g. CGI and age did not have a normal distribution), non-parametric statistical analyses were carried out. Correlations between quantitative variables were evaluated with Spearman's rho test. A $p < 0.05$ was considered statistically significant.

Results

The sample population was recruited over a period of 18 months. A total of 83 patients were included, with a mean age of 46.75 (± 15.33) years (*range* 17-82); there were 51 females and 32 males. The presence of disorders according to DSM-IV TR criteria, are shown in Table 1. Mood and anxiety disorders were present in similar proportions (42.17% and 38.55%, respectively).

From a descriptive analysis of the psychometric parameters evaluated (Table II), the sample cohort had intermediate levels of dissociation from normal (DES <20), intermediate levels of clinically-significant anxiety and depression (HAM-D and HAM-A >17) and moderate global clinical levels of disease (mean CGI = 4); the level of psychopathology as revealed by the self-administered SCL90-R (GSI) test was clinically significant (GSI > 0.566).

The psychopathological dimension of the SCL90-R most frequently seen was depression, obsessive-compulsive, anxiety, somatization, paranoid ideation and interpersonal sensitivity. The indices of psychopathological severity from the GSI and CGI were significantly correlated with the severity of dissociative symptomology (DES). Each psychopathological dimension investigated using the SCL90-R test showed a significant correlation with the dissociative symptomology score ($p < 0.001$). The Hamilton scales did not show any significant correlation with the severity of dissociation.

TABLE I.
Stratification of the sample according to diagnostic area. *Stratificazione del campione in funzione delle aree diagnostiche DSM IV-TR.*

Diagnostic area	N	%
Anxiety disorders	32	38.55
Mood disorders (monopolar)	18	21.69
Mood disorders (bipolar)	17	20.48
Adaptive disorders	11	13.25
Somatoform disorders	5	6.03

Conclusions

The aim of the present study was to investigate correlations between severity of psychopathological manifestations and dissociative symptomology. Our results showed that the intensity of dissociative symptoms appeared to be directly proportional to the severity of the psychopathological dimensions considering both the GSI and CGI. In addition, the severity of dissociation seems to be correlated with severity of each psychopathological dimension assessed with the SCL90-R. Previous studies have shown a relationship between some psychopathological dimensions and dissociative symptomology in patients grouped by the type of disorder [5-8]. It has also been demonstrated that in patients with dissociative disorders the psychopathological dimension of the SCL90-R was significantly higher compared to psychiatric patients that were not affected by dissociative disorders [10]. The data from our patient cohort allowed for the individuation, in a transnosographic manner, of a close relation between psychopathological severity and the level of dissociation. From a clinical standpoint, in our opinion, these results should prompt considerations regarding the relevance of dissociative symptomology during a psychiatric visit as a tool for future integrated and personalized approaches to treatment. Considering psychological disturbances in a hodological context, or as the manifestations of functional disconnection between different brain areas, as suggested by Ffytche [11], the results of our study are suggestive of the possibility that the dissociative symptomology represents a quantitative manifestation of alterations in cerebral circuits; at the same time, the psychopathological dimensions would qualitatively identify areas that are disconnected. Such a hodological vision of psychopathology, lastly, brings us back to the definition of dissociative disorders as a manifestation of *désagrégation* of brain function originally described by Janet. Further studies on larger patient series, using neuroimaging techniques, instruments to assess neurophysiopathological function and mental tests, are needed to evaluate the reliability of our results and their interpretation.

TABLE II.
Descriptive statistics and correlations. *Statistica descrittiva e correlazioni.*

Descriptive Statistics			Statistical correlation	
Parameter	Mean	SD	Correlation coefficient Spearman's rho test	Sig (2 code)
DES	13.800	14.900	1.000	–
Ham-A	18.870	4.420	- 0.075	0.533
Ham-D	16.980	4.670	0.117	0.326
CGI	4.000	0.563	0.233	0.049
GSI	1.286	0.687	0.757	0.000
Somatization	1.302	0.787	0.497	0.000
Obsessive/compulsivity	1.575	0.949	0.677	0.000
Interpersonal sensitivity	1.172	0.871	0.716	0.000
Depression	1.703	0.878	0.603	0.000
Anxiety	1.514	0.809	0.540	0.000
Anger/hostility	0.873	0.802	0.655	0.000
Phobic anxiety	0.775	0.920	0.396	0.000
Paranoid ideation	1.196	0.964	0.616	0.000
Psychoticism	0.892	0.761	0.725	0.000

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