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MINIREVIEWS

Dissociative symptoms and dissociative disorders comorbidity in obsessive compulsive disorder: Symptom screening, diagnostic tools and reflections on treatment

Hasan Belli

Hasan Belli, Department of Psychiatry, Bagcılar Education and Research Hospital, Bagcılar, Istanbul 34400, Turkey
Author contributions: Belli H contributed to this paper.
Correspondence to: Hasan Belli, MD, Associate Professor, Department of Psychiatry, Bagcılar Education and Research Hospital, Merkez Mahallesi, Bagcılar, Istanbul 34400, Turkey. hasan.belli@hotmail.com
Telephone: +90-212-4404002 Fax: +90-212-4404000
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Abstract

Borderline personality disorder, conversion disorder and obsessive compulsive disorder frequently have dissociative symptoms. The literature has demonstrated that the level of dissociation might be correlated with the severity of obsessive compulsive disorder (OCD) and that those not responding to treatment had high dissociative symptoms. The structured clinical interview for DSM-IV dissociative disorders, dissociation questionnaire, somatoform dissociation questionnaire and dissociative experiences scale can be used for screening dissociative symptoms and detecting dissociative disorders in patients with OCD. However, a history of neglect and abuse during childhood is linked to a risk factor in the pathogenesis of dissociative psychopathology in adults. The childhood trauma questionnaire-53 and childhood trauma questionnaire-40 can be used for this purpose. Clinicians should not fail to notice the hidden dissociative symptoms and childhood traumatic experiences in OCD cases with severe symptoms that are resistant to treatment. Symptom screening and diagnostic tools used for this purpose should be known. Knowing how to treat these pathologies in patients who are diagnosed with OCD can be crucial.

Key words: Dissociation; Obsessive compulsive disorder; Screening and diagnostic tools

Core tip: The literature has demonstrated that the level of dissociation might be correlated with the severity of obsessive compulsive disorder (OCD) and that those not responding to treatment had high dissociative symptoms. The structured clinical interview for DSM-IV dissociative disorders, dissociation questionnaire, somatoform dissociation questionnaire and dissociative experiences scale can be used for screening dissociative symptoms and detecting dissociative disorders in patients with OCD. However, a history of neglect and abuse during childhood is linked to a risk factor in the pathogenesis of dissociative psychopathology in adults. The childhood trauma questionnaire-53 and childhood trauma questionnaire-40 can be used for this purpose.

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INTRODUCTION

The term dissociation was used by James in 1890 from the translation of the French term *désagrégation* after it was described by Pierre Janet in 1889. Pierre Janet described dissociation as the deterioration in the unification of experiences at the mental level. These experiences consisted of perception, memory, cognition and emotions. Normally, these experiences all together constituted wholeness in the stream of mind[1,2]. Patients perceive dissociation as dispersion in the wholeness of sense of self. This

dispersion emerges as the deterioration in the unity of chronological, biographic and perceptive identity[2,3].

Dissociative disorders were first described as categorical independent nasographical cases in the Diagnostic and Statistical Manual of Mental Disorders (DMS-Ⅲ) which was published in 1980. Before that, they were among the phenomena associated with dissociative symptomatology hysteria[1,2].

According to DSM-IV-TR, dissociation is described as the deterioration in the integrative functions of consciousness, like the perception of memory, identity and environment. On the other hand, in the etiology of dissociation, traumatic experiences, especially like childhood abuse, take an important place[4,5]. Dissociation functions as the autohypnotic defense mechanism that provides the psychological wholeness of the individual against these traumas[6]. Dissociative disorders contain a group of clinical syndromes associated with the deterioration of one or more of these features described. Dissociation may have a sudden or gradual, temporary or chronic stream. Among the dissociative disorders, the type that has the most chronic and complex features and that contains all the other dissociative phenomena is the dissociative identity disorder. Other dissociative disorders are depersonalization disorder, dissociative amnesia and dissociative fugue disorder. On the other hand, the category that does not meet the specific diagnostic criteria is described as the dissociative disorder that cannot be named otherwise. According to some writers, in cases when the prevalence of dissociative disorders is used as a base for the DSM-Ⅳ diagnosis criteria in clinical practice, it cannot be estimated. These disorders may go unnoticed in clinical practice and it is thought that they are more widespread than estimated. Besides, there is no research based on large populations[2,3]. However, according to recent research, the frequency is estimated to be 5.6% to 10% in the general population[1]. Despite the fact that they are a separate diagnostic category on their own, dissociative symptoms can be observed together with almost all the psychiatric disorders. They can affect the clinical stream of the psychiatric disorders that they are found with[7]. Dissociative symptoms are frequently found with borderline personality disorder[8,9], conversion disorder[10] and obsessive compulsive disorder[11].

Obsessive compulsive disorder (OCD) is a disorder frequently encountered and its lifelong prevalence is between 1% and 3%[4]. OCD is an illness that generally has a chronic stream. This disorder is characterized by obsessions or compulsions, takes very much of the person's time and causes intense stress or affects the individual's personal life[12].

DISSOCIATIVE PROCESSES AMONG PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER

OCD is phenotypically very heterogeneous. This disease has several manifestations, with various dimensions regarding symptoms. In this study, 50 patients who had been diagnosed with OCD were investigated in terms of dissociative symptoms and the relationship of these with symptom dimensions of OCD. In general, dissociative scores were correlated with the level of severity of OCD. However, the controlling dimension was the parameter that was most closely correlated with dissociation. Amnesic dissociative symptoms were found to be correlated with controlling compulsive scores[11].

Rufer *et al*[13] evaluated 52 patients with the diagnosis of OCD. In this study, Cognitive Behavioral Therapy (CBT) was administered to patients for 9.5 wk on average and patients received exposure therapy. In this study group, a high level of dissociative symptoms was detected in patients who ceased treatment because of non compliance. In 43 patients who continued the treatment, however, those with severe OCD symptoms and not responding to the treatment had high dissociative symptoms. In this study, it was reported that high dissociative symptoms can be an indicator for poor response to CBT.

In a study where Belli *et al*[14] included 78 OCD cases, a significant relationship between severity of obsessive compulsive symptoms and dissociative symptom levels was detected. Dissociative disorder dual diagnoses were also investigated using SCID-D. The rate of having at least one dissociative disorder in study group was 14%. In this study, the most common dissociative disorder was depersonalization disorder, followed by dissociative amnesia and dissociative identity disorder. These diagnoses indicated that complicated dissociative disorders accompanied OCD considerably. In another study, Belli *et al*[15] found high levels of dissociative symptoms and a significant correlation between these symptoms and obsessive compulsive symptoms was noted. However, no significant relationship between dissociative symptoms and childhood traumatic experiences was detected.

Semiz *et al*[16] divided the patients into two groups in a study which included 120 OCD patients. Fifty-eight of these patients constituted the treatment-resistant group, whereas the treatment-responding group included 62 patients. The groups were compared to each other. The treatment-resistant group had a higher level of disease severity, dissociative symptoms and childhood traumas. The results of this study suggested that dissociative symptoms and childhood traumatic experiences can precede poor response to treatment.

In another study, Selvi *et al*[17] investigated 95 OCD patients from a different aspect. In this study, the relationship between possible dissociation, childhood trauma and cognitive processes in patients with OCD was investigated. It was found that dissociative symptomatology was strongly related to pathological processes that constituted OCD symptoms.

One of the most important methods for the treatment of OCD is Cognitive Behavioral Therapy (CBT). Pathological cognitive processes are looked for in the

formulation of treatment in OCD. However, no adequate response to CBT was reported in 30%-60% of cases. This also requires consideration of multifactorial intrapsychic structures that constitute OCD. The hypnotherapeutic approach that focuses on dissociative phenomena is one of the most important of these factors. Hypnotherapeutic approaches can also be used in the treatment of OCD[18]. It was reported that dissociative symptomatology can be a very important factor in not responding to treatment. This condition can involve not only treatment resistance to CBT, but also cases who do not adequately respond to medication[19]. However, the relationship between dissociative symptomatology with childhood traumatic experiences was well established. Hypnotherapeutic approaches can also be used in repairing the traumatic memory[20]. It is apparent that systematic studies are needed to measure the efficiency of hypnotherapeutic approaches in treatment resistant cases in regards to relevant dissociative pathology. Ego state therapy, a systematic approach in which hypnotic phenomena are used[21], can be beneficial in the treatment of complex conditions, such as the dissociative amnesia or dissociative identity disorder that accompany OCD.

ASSESSMENT OF DISSOCIATION SYMPTOMS AND CHILDHOOD TRAUMATIC EXPERIENCES IN PATIENTS USING THE TOOLS AND SCALES

The structured clinical interview for DSM-IV dissociative disorders

SCID-D is a semi-structured interview tool developed by Steinberg. It is used to explore and determine the dissociative disorders according to DSM-IV. By using this interview tool, dissociative identity disorder, depersonalization disorder, dissociative amnesia, dissociative fugue and the dissociative disorder diagnoses that cannot be named otherwise can be established. Because of the fact that the dissociative identity disorder diagnosis can meet the symptoms of all the other diagnosis categories, it is generally established on its own. If this diagnosis is established, then generally no other diagnoses are established[22].

Dissociation questionnaire

This scale was developed by Svedin *et al*[23]. By using this scale, dissociative experiences are explored and the severity of these symptoms is evaluated. This scale can be used to explore the traumatic experiences of psychiatry patients and consists of 63 questions. Individuals mark the choices appropriate to them. Every heading is evaluated by a point between 1 and 5 and the average score is obtained by dividing the total points by 63[23].

The somatoform dissociation questionnaire

This scale is a self-rating instrument that consists of 20 articles that patients themselves fill out, used in the exploration of somatoform symptoms of patients who have had traumatic experiences. Every heading is evaluated by a point between 1 and 5 and the average score is obtained by dividing the total points by 20. This scale was developed by Nijenhuis *et al*[24].

The dissociative experiences scale

This scale is a psychological self-rating instrument that evaluates dissociative symptoms. The scale contains 28 questions, a general score and four sub scales. Every heading is evaluated by a point between 0 and 100 and the average score is obtained by dividing the total points by 28[25].

A history of neglect and abuse during childhood is linked to a risk factor in the pathogenesis of dissociative psychopathology in adults[5,26-29]. Dissociation is also linked to traumatic life events, especially childhood traumas[30]. Therefore, childhood traumas must be investigated when dissociative symptoms are found in patients with an OCD diagnosis. This could be very important in planning treatment and the following scales can be used for this purpose.

Childhood trauma questionnaire (CTQ-53)

This is a self-rating scale developed by Bernstein *et al*[31] consisting of 53 questions. With this scale, childhood emotional, physical and sexual abuse and childhood physical and emotional neglect situations are evaluated. Points between 1 and 5 are given for all types of possible childhood traumas and the total of the points are derived from the total points of every childhood trauma between 5 and 25. The measurement also contains the minimization/denial scale that has three headings and is potentially out of the rating[31]. The 3 items comprising the minimization/denial scale are dichotomized (never = 0, all other responses = 1) and summed; a total of one (1) or greater "suggests the possible underreporting of maltreatment" false negatives.

Childhood trauma questionnaire (CTQ-40)

This scale was developed by Bernstein *et al*[31]. It consists of 40 questions and every question has five choices. It is a self-rating scale that explores childhood traumatic experiences before the age of 18. The answers are composed of five choices. These answers are: never (1); rarely (2); sometimes (3); often (4); and very often (5). High scores reveal that abuse in adolescence and childhood took place very often. The total points are between 40 and 200[31].

CONCLUSION

OCD is a disorder with high lifelong prevalence that can severely deteriorate the quality of life. Therefore, every aspect influencing the development and treatment of this disorder should be addressed seriously.

The individuals diagnosed with OCD can be evaluated in three categories in an etiological context. These dimensions can be classified as cognitive, biological and

emotional[32,33]. Some writers emphasize the importance of traumatic dissociative, existential and acquired developmental factors in the etiology of OCD of some patients in the emotional dimension. For many years, various treatments have been suggested for the treatment of OCD. It is frequently emphasized that cognitive behavioral therapy is one of the most effective treatment methods[34]. Some authors[20,35,36] indicated that the therapist should target the stress eugenic factors that are acquired in intrapsychic and developmental ways and that contain conflicts, existential traumas and dissociated pieces of personality in order for the OCD symptoms to be treated successfully. However, the relationship between dissociative symptomatology and childhood traumas has not been clearly defined. To a large extent, dissociation is especially related to childhood abuse[26,37]. Dissociation functions as the autohypnotic defense mechanism that provides the psychological wholeness of the individual against these traumas[4,5]. In addition to the cognitive behavioral model, different methods can also be used in the treatment of dissociative symptoms and chronic dissociative disorders. Some writers stated that ego state therapy and hypnotherapy can be effective on dissociative processes. In the ego state therapy, hypnotic phenomena are used as the basic technique. In this therapy method, it is thought that the self develops in a fragmented way and functions by becoming integrated. Childhood trauma and stresses can disrupt this integrity. During the therapy, these childhood experiences are concentrated on again in order to fix the disrupted integrity. It is apparent that systematic studies are needed to measure efficiency of hypnotherapeutic approaches in treatment resistant cases in regard to relevant dissociative pathology. Ego state therapy is a systematic approach in which hypnotic phenomena are used[20,21].

Investigating the dissociative symptoms, complex dissociative disorders and childhood traumas is very important in patients who are diagnosed with OCD. Clinicians should not fail to notice the hidden dissociative symptoms and childhood traumatic experiences in OCD cases with severe symptoms and resistant to treatment. Symptom screening scales and diagnostic tools used for this purpose should be known. To know how to treat these pathologies in patients who are diagnosed with OCD, particularly in cases with resistance to treatment, can be crucial.

OCD is a disease with high lifelong prevalence that can severely deteriorate the quality of life. The literature has demonstrated that the level of dissociation might be correlated with the severity of OCD and that those not responding to treatment had high dissociative symptoms.

It is important to know the scales that explore the dissociative symptoms and childhood experiences for patients diagnosed with OCD. Apart from that, the tools that serve to diagnose complex and chronic dissociative disorders can also help. More research that investigates the relationship between OCD and dissociative processes are needed. These studies need to have a large sample size that comprises both genders. As these studies increase, serious developments will take place in treatment plans.

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