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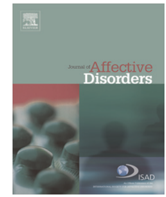

Research report

Dissociation in bipolar disorder: Relationships between clinical variables and childhood trauma

Aytül Gursu Hariri [a], Medine Yazici Gulec [b,*], Fatma Fariha Cengiz Orengul [c], Esra Aydin Sumbul [b], Rumeysa Yeni Elbay [b], Huseyin Gulec [b]

[a] Psychiatry Department, Maltepe University, Istanbul, Turkey
[b] Erenkoy Psychiatry and Neurological Disorders Research and Training Hospital, 34736 Kadikoy, Istanbul, Turkey
[c] Haseki Research and Training Hospital, Istanbul, Turkey

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A B S T R A C T

Objective: The dissociative experiences of patients with bipolar disorder (BD) differ from those of patients with other psychiatric disorders with regard to certain features. The primary goal of this study was to evaluate the relationship between the clinical variables of BD and childhood trauma using the factor structure, psychometric features, and potential subdimensions of the Dissociative Experience Scale (DES).

Method: This study included 200 BD patients who were in a remission period and 50 healthy volunteers. The BD patients were recruited from two psychiatry clinic departments in Turkey. The sociodemographic data of the two groups and their scores on the DES and Childhood Trauma Questionnaire (CTQ)-28 were compared.

Results: The overall DES scores and the scores for each DES item accurately and reliably measured dissociation in the BD patients (item–total correlation r scores: >0.20, Cronbach's alpha: 0.95), and a factor analysis revealed two subdimensions of the DES for BD: identity confusion/alteration (SubDES-1) and amnesia and depersonalization/derealization (SubDES-2). Although age at onset of BD was significantly correlated with both subdimensions, illness duration was significantly correlated only with the SubDES-2. Of all the subjects, 19.5% (39/200 patients) were identified as having dissociative experiences by the DES-Taxon (DES-T), and subjects in this subscale (DES-T-positive) had significantly higher total scores on the CTQ-28 as well as higher scores on each subgroup of this scale. The highest CTQ-28 subgroup score was emotional neglect, which was followed by emotional abuse and physical neglect and then sexual abuse and physical abuse. There was a significant correlation between total scores on the CTQ-28 and SubDES-2 but none of the CTQ-28 subscale scores was significantly correlated with either SubDES-1 or SubDES-2.

Conclusion: The DES sufficiently and reliably identified the experience of dissociative symptoms on the part of BD patients, and a factor analysis revealed two subdimensions of BD on this scale. In particular, DES-T-positive subjects experienced a greater amount of childhood trauma and, as a result, had an earlier age at onset of BD. Additionally, SubDES-2, which was associated with amnesia and depersonalization/derealization, was closely related to illness duration.

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1. Introductıon

Bipolar disorder (BD) typically manifests as clinical episodes in which individuals cycle between distinct affective episodes and euthymia (Latalova et al., 2010). In addition, the nonaffective psychopathological elements of a BD episode and the subsyndromal affective symptoms present during the euthymic remission stage strongly influence the social functioning of many patients (Latalova et al., 2010).

Dissociation is considered to be a coping strategy used to deal with strong anxiety states and debilitating traumatic experiences (Merckelbach et al., 1999; Lochner et al., 2004; Latalova et al., 2010, 2011). As many as 80% of individuals report experiencing some form of dissociative phenomena during their life (Lochner et al., 2004). Dissociation is linked with a variety of psychiatric conditions including borderline personality disorder, anxiety disorders, eating disorders, schizophrenia, and affective disorders. Several studies (Lochner et al., 2004; Maaranen et al., 2008; Latalova et al.,

* Corresponding author. Tel.: +90 216 302 5959.
E-mail address: yazicimedine@yahoo.com (M.Y. Gulec).

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2010, 2011) have identified a close relationship between dissociation and affective symptoms, especially depression, but the prevalence and clinical correlates of dissociative symptoms in BD patients have received limited attention. However, a few studies have investigated the characteristics of dissociation in BD patients, although a history of abuse or trauma is evident in nearly 50% of adults with BD (Garno et al., 2005; Oedegaard et al., 2008; Lu et al., 2008; Mula et al., 2009; Watson et al., 2013). According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), dissociative symptoms are experienced as (a) unbidden intrusions into awareness and behavior, accompanying losses of continuity in subjective experience (i.e., "positive" dissociative symptoms such as fragmentation of identity, depersonalization, and derealization) or (b) an inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., "negative" dissociative symptoms, such as amnesia). This feature of dissociation is particularly evident in the risk-taking behaviors of BD, especially during manic or mixed episodes. In fact, individuals who have experienced negative life events take as much as three times longer to show improvements in mood disorder symptoms (Johnson and Miller, 1997).

There is a close relationship between the presence of dissociative symptoms and childhood trauma. A large number of clinical and non-clinical studies have demonstrated that dissociative experiences are correlated with self-reports of traumatic childhood events such as sexual or physical abuse and emotional or physical neglect (Chu and Dill, 1990; Engel et al., 1996; Lange et al., 1999; Sandberg and Lynn, 1992; Sanders and Giolas, 1991; Zlotnick et al., 1995, 1996; Mulder et al., 1998; Brietzke et al., 2012). A history of childhood trauma and dissociative disorders can be identified in a variety of populations (Chu and Dill, 1990; Akyuz et al., 1999; Sar et al., 2000; Merckelbach and Muris, 2001; Edwards et al., 2003), but adverse childhood experiences and dissociation are more frequently reported in patients with psychiatric disorders (Saxe et al., 1993; Tutkun et al., 1998; Nijman et al., 1999; Gast et al., 2001; Tezcan et al., 2003; Lochner et al., 2004; Karadag et al., 2005; G.R. Brown et al., 2005; R.J. Brown et al., 2005; Watson et al., 2006, 2013; Foote et al., 2006; Oedegaard et al., 2008; Lu et al., 2008; Maaranen et al., 2008; Davidson et al., 2009; Sugaya et al., 2012; Mauritz et al., 2013; Larsson et al., 2013a; Erten et al., 2014). In BD patients, there are indications that childhood traumas are associated with clinical characteristics (Etain et al., 2010; Larsson et al., 2013b; Perich et al., 2014), such as an earlier onset of BD (Garno et al., 2005), a greater number of psychotic episodes (Hammersley et al., 2003), more suicide attempts (McIntyre et al., 2008), a greater number of lifetime mood episodes (Johnson and Miller, 1997), a more rapidly cycling disease course (Etain et al., 2010, 2013; Larsson et al., 2013b) and higher rates of comorbidity with other psychiatric disorders such as drug abuse and personality disorders (Brietzke et al., 2012).

The conceptualization of dissociation as a trait suggests that this feature differs across individuals, exists on a continuum, will show stability in different situations, and can be assessed using objective measures such as the Dissociative Experiences Scale (DES). The DES is a self-report measure developed by Bernstein and Putnam (1986) to screen for dissociative psychopathologies in normal and clinical populations. This scale assesses the type and frequency of dissociative experiences, which include amnesia, derealization, depersonalization, absorption, and alterations of identity (Waller and Ross, 1997; Merckelbach et al., 1999). Factor analyses of the DES have consistently revealed three sub-phenomena of dissociative experiences: (1) absorption, (2) derealization/depersonalization, and (3) amnesia (Ross et al., 1991; McLeod et al., 2004). Waller et al. (1996) proposed a dissociative taxon to aid in the identification of individuals experiencing states of pathological dissociation, which should be distinguished from non-pathological dissociative states, and this can be accomplished using the DES-Taxon (DES-T). Based on the taxon view of dissociation, it may be assumed that trauma-induced forms of dissociation are distinct from more typical alterations in consciousness.

Consequently, the primary objectives of this study were to evaluate the capability and reliability of the DES to assess BD patients and to determine the level of dissociation in patients with BD using the DES. The secondary aim of this study was to evaluate the relationships of the DES-T index with the sociodemographic variables and childhood traumas of BD patients.

2. Methods

2.1. Subjects and instruments

This study enrolled 200 patients between the ages of 18 and 64 years who had been diagnosed with BD (71 men: mean age = 39.0 ± 12.4 years, mean duration of education = 8.6 ± 4.0 years; 119 women: mean age = 38.2 ± 10.5 years, mean duration of education = 8.7 ± 4.3 years).

The healthy control (HC) group, which was balanced according to age, sex, and education, consisted of 50 hospital staff members and their relatives (17 men: mean age = 40.6 ± 9.6 years, mean duration of education = 8.8 ± 3.8 years; and 33 women: mean age = 38.8 ± 11.4 years, and mean duration of education = 9.2 ± 3.2 years). According to previous medical records and their own declarations, members of the HC group had no history of psychiatric or medical conditions.

All BD patients were diagnosed using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; Spitzer et al., 1987) and were at least 2 months into a period of remission. We used the Hamilton Anxiety Rating Scale (HARS; Hamilton 1959; Yazici et al., 1998), Hamilton Depression Rating Scale (HDRS; Hamilton, 1960; Akdemir et al., 1996), and Young Mania Rating Scale (YMRS; Young et al., 1978; Karadag et al., 2001) to establish the remission status of patients. All subjects gave informed consent before inclusion in the study.

A semi-structured form that gathered data about sociodemographic (sex, age, education, marital status, etc.) and clinical (e.g., age at onset, duration of condition, and number of episodes) variables was used in the study.

Traumatic childhood events were assessed with the Childhood Trauma Questionnaire (CTQ-28; Bernstein et al., 1994; Sar et al., 2012), and the Dissociative Experience Scale (DES; Bernstein and Putnam, 1986; Carlson and Putnam, 1993; Yargic et al., 1995) was used to measure dissociation.

The included patients met the DSM-IV-R research criteria for bipolar disorder, were 18–65 years of age, and had a HARS score <7, a HDRS score <7, and a YMRS score <12. Patients were excluded if they had cognitive disorders, mental retardation, and mental disorders due to a general medical condition, schizophrenia, delusional or other psychotic disorder, substance dependence, serious somatic or neurologic diseases, a history of personality disorder, or a current depressive or manic episode.

The DES is the scale use most commonly for measuring dissociation in a dimensional manner in both clinical and nonclinical samples. A 28-item self-report screening instrument for dissociative disorders with possible scores of 0–100% developed by Bernstein and Putnam (1986), the DES measures the frequency of dissociative experiences, such as autobiographical amnesia, derealization, depersonalization, absorption, and identity alteration. The items on the DES were constructed using data from interviews with subjects meeting the DSM-III criteria for dissociative disorders and from consultations with clinical experts in the treatment of dissociative

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