Is There a Dissociative Subtype of Generalized Social Phobia?

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Abstract

Objective: Dissociation in individuals with dissociative syndromes is primarily related to traumatic and/or shameful experiences. These situations may be re-experienced every time the individual is in a public arena and can lead to the manifestation of generalized social phobia (GSP). Therefore, the aim of this study was to investigate the severity of dissociative symptoms and the relationship of these symptoms to GSP.

Method: This study included 35 healthy volunteers and 51 patients with a diagnosis of GSP who visited the psychiatric outpatient clinic at the Y. Public Hospital or the B. University Medical Faculty Hospitals. All 51 patients with GSP completed the Liebowitz Social Anxiety Scale (LSAS), and the Dissociation Questionnaire (DIS-Q) was completed by the 51 patients as well as the 35 healthy volunteers.

Results: All participants completed the scales during their first session prior to the initiation of any treatment. The median LSAS anxiety score was 69.03 ± 7.64 and the mean avoidance score was 59.35 ± 7.35 in the GSP patient group. The mean DIS-Q score was 2.44 ± 0.59 in the GSP group and 1.67 ± 0.38 in the control group. GSP patients reported a significantly greater number of dissociative symptoms than did the control group (Z=6.00, P<0.001), and a moderately strong positive correlation was found between LSAS anxiety scores and DIS-Q scores (rho=0.308, P<0.05) in GSP patients.

Conclusion: Higher levels of dissociative symptoms were reported by GSP patients than by healthy controls. These findings indicate that dissociative symptoms may develop during the daily traumatic experiences to which individuals with GSP are exposed in social settings.

Keywords: Social phobia; Dissociation; Traumatic experience; Symptoms

Introduction

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR), a major characteristic of social phobia is the sustained experience of extreme fear in social situations, such as the fear of a shameful public performance. Occasionally, anxiety symptoms may emerge when an individual with social phobia is faced with performing in public, and this can develop into a panic attack [1]. A recent epidemiological study investigating social phobia found a lifetime prevalence of 4.9% in men and 9.5% in women [2]. Another epidemiological study conducted in France found a lifetime prevalence of 14.4% and reported that social phobia is the third most common mental disorder in that population [3]. It is thought that a combination of genetic and environmental factors contribute to the etiology of social phobia [4], which is categorized as either “limited” or “generalized” by the 10th revision of the International Classification of Diseases (ICD-10) and either “generalized” or “non-generalized” by the DSM-IV-TR.

Hypothetical thoughts or feelings experienced in a social situation can produce anxiety in a social phobic individual. According to this model, these anxiety symptoms are perceived by the individual as dangerous and salient, and an ongoing vicious cycle of symptoms and anxiety-coping strategies may occur [5]. Clinically anxious individuals can experience spontaneous visual images of themselves in social situations, and these images, somatic symptoms (e.g., palpitations), worries, anxious thoughts, negative emotions about themselves, and memories of actual social events may arise from interoceptive sources [6].

Dissociation is an interruption between the normal and subjective union of one or more psychological functions, perception, motor control, identity, memory, and awareness [7,8]. Many instances of acute dissociation are primarily related to traumatic and/or shameful experiences that the individual has endured [7]. Dissociative symptoms are also included in the diagnostic criteria for acute stress disorder, post-traumatic stress disorder, and somatization disorder [1], and a strong relationship exists between the stressors that usually result in dissociative symptoms and childhood trauma as well as physical, sexual, or emotional abuse [9-11].

Recently, there has been an interest in the possible relationship between social anxiety and dissociation [12,13]. This approach does
not conflict with accepted ideas regarding dissociation because dissociative disorders not only contribute to the development of psychological disorders but also influence interpersonal relationships [14]. A complicated relationship exists between social anxiety and dissociative symptoms, and we propose that dissociative symptoms are common in patients with generalized social phobia (GSP). Thus, this study aimed to investigate the incidence and severity of dissociative symptoms in patients with GSP and to examine how these symptoms affect the diagnosis and treatment of this disorder.

Materials and Methods

All procedures in this study were undertaken according to the Declaration of Helsinki. Approval was granted by the Institutional Review Board of the B. University Medical Faculty Noninvasive Clinical Studies Ethics Committee, and all participants provided informed consent.

Sampling

This study included 51 outpatients (35 female and 16 male) diagnosed with GSP who presented at the psychiatry clinic of Y. Public Hospital or B. University Hospital between March and July of 2013. The mean age of the patients was 29.66 ± 7.19 years (range: 18–49 years). The control group included 35 healthy subjects (19 women and 16 men) with a mean age of 31.88 ± 7.09 years (range: 21-55 years). Those without GSP; those with a comorbid neurological, psychiatric, or medical condition or alcohol and/or drug use disorders; and those whose use of steroids resulted in psychiatric syndromes were excluded.

Data Collection and Scales

Demographic information form

The form used to collect demographic information was developed by the co-authors of the present study and included questions regarding the age, sex, educational status, and marital status of the participants.

Liebowitz Social Anxiety Scale (LSAS)

The Liebowitz Social Anxiety Scale (LSAS) was developed to assess the levels of avoidance and anxiety experienced by individuals with social phobia in interactive public situations and was designed to be administered by an interviewer with knowledge of this psychopathology. This scale is primarily used for individuals with social phobia but can easily be applied as a screening tool for groups without GSP; those with a comorbid neurological, psychiatric, or medical condition or alcohol and/or drug use disorders; and those whose use of steroids resulted in psychiatric syndromes were excluded.

Dissociation questionnaire

The DIS-Q was developed by Vanderlinden [17]. The Dissociation Questionnaire (DIS-Q) is a self-assessment test used to measure the severity of dissociative experiences and disorders in non-clinical and clinical samples with traumatic experiences. This scale consists of 63 items scored from 1 to 5. The sum of these scores is divided by 63, and a total average score is calculated. A Turkish study found that individuals with scores at least 2.5 points higher than the average score had a high probability of having a dissociative disorder. The DIS-Q was adapted into Turkish by Şar [18].

Application

The demographic and clinical data of the participants were recorded on an information form developed by the investigators. Patients with GSP were diagnosed by two psychiatrists using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Patients in this study completed the LSAS and the DIS-Q, whereas those in the control group completed only the DIS-Q.

Statistical Analysis

This work is an analytical study. All statistical analyses were conducted using SPSS version 17 (SPSS Inc.; Chicago, IL, USA), and descriptive statistics were analyzed in terms of medians and standard deviations. Scores on the LSAS and DIS-Q were compared between groups using the Mann–Whitney U test and Spearman correlation analysis was employed to evaluate the relationship between scores on these two tests. A p value <0.05 was considered to be statistically significant.

Results

The mean ages were 29.66 ± 7.19 years in the GSP group and 31.88 ± 7.09 years in the control group (P=0.12). GSP patients had a mean of 10.94 ± 2.88 years of education, whereas those in the control group had a mean of 12.03 ± 3.02 years of education (P=0.09). The GSP group consisted of 23 married, 26 single, and two divorced participants, whereas the control group consisted of 21 married, 13 single, and one divorced subject. Thus, there were no statistical differences between the GSP and the control group (Table 1).

<table>
<thead>
<tr>
<th>S.Phobia</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>51</td>
</tr>
<tr>
<td>AGE (YEAR) (Mean ± SD)</td>
<td>29.66 ± 7.19</td>
</tr>
<tr>
<td>EDUCATION (YEAR) (Mean ± SD)</td>
<td>10.94 ± 2.88</td>
</tr>
<tr>
<td>GENDER</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>16</td>
</tr>
<tr>
<td>MARITAL STATUS</td>
<td>Married</td>
</tr>
<tr>
<td></td>
<td>23</td>
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<td>2</td>
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</tbody>
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Table 1: Sociodemographic data of groups
S.PHOBIA CONTROL Statistic

<table>
<thead>
<tr>
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<th>S.PHOBIA</th>
<th>CONTROL</th>
<th>Statistic</th>
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<tbody>
<tr>
<td>N</td>
<td>51</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Anxiety(M±SD)</td>
<td>69.03 ± 7.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance(M±SD)</td>
<td>59.35 ± 7.35</td>
<td>*Z=-6.00</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIS_Q (M±SD)</td>
<td>2.44 ± 0.59</td>
<td>1.67 ± 0.38</td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>

Table 2: Descriptive statistics and statistical comparison of groups, *MWU

<table>
<thead>
<tr>
<th></th>
<th>Libovitz_Angli</th>
<th>Libovitz_Avoid</th>
<th>Dis_Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>Libovitz_Angli</td>
<td>rho 1.000</td>
<td>0.828**</td>
<td>0.308*</td>
</tr>
<tr>
<td>P</td>
<td>0.000</td>
<td>0.028</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>51</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Libovitz_Avoid</td>
<td>rho 0.828**</td>
<td>1.000</td>
<td>0.273</td>
</tr>
<tr>
<td>P</td>
<td>0.000</td>
<td>0.053</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>51</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Dis_Q</td>
<td>rho 0.308*</td>
<td>0.273</td>
<td>1.000</td>
</tr>
<tr>
<td>P</td>
<td>0.028</td>
<td>0.053</td>
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<tr>
<td>N</td>
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Table 3: Correlations of scales in patient group.

Patients with anxiety are more sensitive to negative feedback than are healthy subjects partially because they have an automatic cognitive impulse to perceive this type of environmental stimulus as negative and/or threatening [20]. Similar findings regarding information processing were observed among women with both high and low levels of dissociative symptoms [21]. The relationship between the symptoms of dissociation and those of social phobia has been established more clearly than has any relationship between the etiologies of these disorders. For example, Simeon et al. [22] evaluated 117 patients with depersonalization disorder and found that 30% of patients met the diagnostic criteria for social phobia and 23% of patients met the diagnostic criteria for avoidant personality disorder. Furthermore, epidemiological investigations have demonstrated that 14.4% of patients with post-traumatic stress disorder experienced dissociative symptoms when in public situations [23]. Similar findings have been reported by other studies [24,25], and dissociation symptoms have also been found to more frequently occur in women than in men [25,26]. Additionally, an experimental study found dissociation-like behaviors observed in male mice with Fragile-X syndrome in two types of anxiety-producing situations. In a Fragile-X mouse model of generalized anxiety, experimental subjects exhibited reduced anxiety in a non-social elevated maze but social anxiety-like impaired performance in a test of social interaction [27].
A history of trauma is observed less frequently in patients with obsessive–compulsive disorder than in those with social anxiety disorder, but patients with obsessive–compulsive disorder do not differ from those with social anxiety disorder in terms of the occurrence of dissociative symptoms [28]. However, the association between childhood trauma and subsequent dissociation in adulthood is supported by the incidence of social anxiety and other anxiety disorders among those who have experienced trauma [29]. A study of men with alcohol dependence found a significantly higher level of social anxiety in the dissociative patient subgroup than in subjects without dissociative symptoms [30]. Moreover, Hunter et al. [31] reported that the prevalence of DR/DP during panic attacks was 7.8–82.6%; however, these findings are not generally accepted in the literature.

The present study found a positive and moderately strong correlation between LSAS anxiety scores and DIS-Q scores in patients with GSP. Although certain aspects of the present study involved only patients with GSP, the findings indicate that dissociative symptoms are quite frequent and severe in this psychiatric population. Dissociative symptoms in GSP patients typically occur in crowded areas, such as shopping centers and meetings. GSP patients are also more likely than normal population to be diagnosed with conditions such as vertigo or vestibular disorders and to avoid psychiatric treatment. Thus, a multidisciplinary approach may be useful for clarifying the nature of the psychiatric impairments in this group of patients.

References