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Review Article

Dissociative Syndromes in Mental Disorders in the Context of a Approach Dimensional

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Received date: April 29, 2024; Accepted date: May 14, 2024; Published date: May 22, 2024

Citation: Aleksandr P. Kotsubinsky, Aleksandr R. Protasov, Yulia V. Isaenko, Daria E. Bolotova, Anastasia A. Stepanova, (2024), Dissociative Syndromes in Mental Disorders in the Context of a Approach Dimensional, *Psychology and Mental Health Care*, 8(5): **DOI:10.31579/2637-8892/279**

Abstract

The personality dimensions isolated in ICD-11 essentially represent a non-psychotic level. However, in the case of the intensification of symptoms and the development of a mental disorder, they may correspond to psychotic dimensions. This awareness allows us to consider each dimension as a phenomenon that reflects a continuum from the non-psychotic to the psychotic level. It is proposed to add dissociative processes that occur in various diseases to the existing dimensions. Guided by the principle of a five-level ranking system for all measurements within the range of 0 to 4, we propose a glossary of specific principles for ranking the dissociative dimension. This diagnostic approach will make it possible to more accurately distinguish between the mental states of patients, based on the severity of their disease and the completeness of their clinical symptoms.

Keywords: dimensions; dissociative syndromes; dissociative processes; dimensional approach; categorical diagnostic approach.

Introduction

The "nosological dictate" that reflected the categorical diagnostic approach has existed in psychiatry for more than a hundred years, but has not resulted in any convincing evidence of the legitimacy of the nosological interpretation of isolated "endogenous" diseases and their fundamental independence from "exogenous" factors, and has disappointed many adherents of the use of the categorical diagnostic approach in psychiatry. As a result, psychiatrists increasingly turned their attention to the long-standing concept of a single psychosis. According to this concept, the different mental illnesses are not, strictly speaking, independent, but are private manifestations and varieties of uniform adaptive and compensatory mechanisms, forming different clinical configurations due to circumstances contingent on the etiology. Such a view makes it imperative to consider mental disorders from the perspective of not only traditionally categorical, corresponding to the nosological approach, but also dimensional characteristics. According to M.L.Esterberg and M.T.Compton [1] The dimensional diagnostic approach: reflects the true continuum of psychosis in the population; eliminates the loss of information that occurs with the categorical approach because it takes into account more clinical information needed to make appropriate treatment recommendations [2]; eliminates the high degree of diagnostic matching criteria currently available and used in the diagnosis of categorical disorders. This improves the predictive power of clinical symptoms, response to treatment, and outcome of the disorder present [1].

The dimensional approach, which is based on the idea of dimensia as a separate (independent) feature of a holistic object, to some extent, leads to the possibility of quantifying the severity of a symptom or the degree of impairment of a particular psychological function. This is due to the fact that the basic meaning of the word "dimensia" is reduced to the possibility of ranking expression of any specific feature of a holistic object [3], defined by the value obtained in the process of measuring this attribute. In ICD-11 and DSM-5 the following psychotic dimensias are distinguished as common: positive (delusional and hallucinatory), depressive, manic, negative, cognitive, psychomotor-catatonic, which are ranked on a 5-point scale [4] as "0" (no symptoms), "1" (doubtful severity), "2" (minor severity), "3" (medium severity), "4" (significant severity), and for cognitive dimensia as "0" (none), "1" (doubtful), "2" (mild), "3" (medium), "4" (severe). In addition to psychotic, there are also personality dimensia (negative affectivity, dissociation, detachment, disinhibitory and anankast signs), ranked in the range from 0 (absence of this dimensia) to 4 (severe or significant severity, leading to frequent and prolonged decompensations) [5]. In fact, personality dimensia actually describes the non-psychotic level of expression of those dimensia, which,

with their greater depth, occurring in the development of a mental disorder, are labeled as psychotic. A holistic consideration of the ranking of dimensionalities, in the range of their manifestations from neurotic to psychotic levels of expression, makes it possible to identify a certain dominant dimensional vector of the development of the spectrum of mental disorders. In this connection, we would like to draw attention to such a mental process as dissociation, which is not considered in the already identified psychiatric dimensia and is mentioned only in personality dimensia, but in practice in a number of cases reaches psychotic manifestations in the development of psychiatric disorders and, therefore, requires additional attention and consideration to address whether it can be identified as a separate dimensia. In a study by Farina B et al, in which a definition of psychopathological outcomes associated with childhood traumatic events and dissociative processes is proposed, the so-called "traumatic-dissociative" dimensia (free translation: "traumatic-dissociative" dimension (TDD)[6], which aggravates the course of the disease and complicates the treatment of such patients, and therefore - requires separate consideration. According to ICD-11, dissociation is described as "an involuntary disruption or break in the normal integration of one or more of the following: personality, sensations, perceptions, affects, thoughts, memories, control of bodily movements or behavior." [7]. Mental trauma and dissociation are two closely related concepts in psychopathology. [8-16]. Clinical and empirical evidence leads to the conclusion that dissociative pathogenetic processes of "attachment" trauma perpetrated by parents or other caregivers produce dissociative symptoms that dominate the clinical presentations of disorders such as PTSD, borderline personality disorder, and dissociative personality disorder, yet may appear in varying degrees of severity in virtually all DSM-IV diagnostic categories as an indicator of severe condition [17]. Thus dissociation (or dissociation) is a mental process that results in the phenomenon whereby an individual's traumatic facts or events begin to be perceived as happening not to him or her but to an outsider; the "dissociated" position protects against excessive, intolerable emotions. Currently, the concept of dissociation is still debated and is a current issue without a clear universally accepted definition [18]. Among others, one of the reasons for the lack of clarity is related to the different uses of the term. It should be noted the existence of two hypotheses with different definitions, mechanisms and treatment implications of the dissociative process: "detachment" (compartment) and "separation" (detachment) [19]. "Detachment", or isolating dissociation (isolating compartment), is a deficit of ability to control mental processes, is formed in personalities of hysteroid circle [20] and is characterized by a violation of the ability to control those mental processes that are normally available to control by consciousness [21]. Isolating compartment is not accompanied by complete separation (alienation) of stress-induced events and is characterized by preservation of the ability to test reality [22; 23]. "Separation" or separating dissociation (detachment) is characterized by complete alienation of awareness of the self as an object of perception [19; 23; 24], i.e. an anomaly of prereflexive self-awareness [25; 26]. In this case, there is a partial or complete elimination from the sphere of "internal reality", not only cognitive, but also emotional, components of the external stressor [19], which sharply decreases critical assessment of the situation, "dysfunctional realitytesting abilities [27], and manifestations of dissociation (alienation of certain mental functions) are more persistent and more extended in time than in isolated dissociation, accompanied by alienation (complete or partial) of the traumatic event and its consequences. Most often, in this case, in the group of dissociative disorders as objects of psychopathological analysis are the phenomena of auto-, allo- and somatopsychic depersonalization, as well as psychic anesthesia (anaestesia psychica dolorosa), when the holistic perception of self is replaced by the feeling of incoherence, disconnectedness [28] up to complete alienation [19; 23; 24] or conversion-dissociative disorders in the form of distorted encoding of information about the event [29; 30; 31]. However, it is known that stress-induced dissociation and related conversion-dissociative disorders in the case of cessation of a stimulus such as trauma or emotional distress usually achieve a rapid reduction of manifestations. However, in some cases, the development of mental disorders is associated with the fact that dissociative manifestations persist for quite a long time, amplification complicating and acquiring a maladaptive character [32]. As a result, some of the patients, initially being in a state of severe stress, later demonstrate most of the schizophrenic symptoms of "level 1" according to Schneider [33], and in the case of observed in them such dissociative switches as mood lability - schizoaffective or bipolar disorder at the psychotic level. This fact makes it possible to consider dissociation as a separate dimensional trait that requires ranking by degree of severity. The purpose of this review is to discuss the possibility of distinguishing dissociative processes as a separate dimensional entity and to present a glossary according to which, based on a five-level assessment of dimensional representation from 0 to 4 (from no feature to severe, corresponding to the psychotic level), dissociative manifestations can be represented in a range from no manifestation (0), questionable severity - non-psychotic level of dissociation disorder (1), and minor severity - amplified level of dissociation disorder (2), medium severity - subpsychotic level of dissociation disorder (3), significant severity of manifestations corresponding to the psychotic level of dissociation disorder (4). The non-psychotic level in this case will be represented by depersonalization and personality dissociation. Depersonalization. It was found that depersonalization phenomena are widespread among individuals without obvious mental disorders in the absence of gender preference. The research conducted by Ruzhenkova V. V. and her colleagues showed that depersonalization symptoms at one time or another were detected in 94% of the students they examined, which more often occurred in persons with personality disorder, neurotic and stress-related disorders. [34.]. According to the data of Usatenko E.V., in the structure of anxiety disorders dissociative symptoms in the form of displacement elements, including partial amnesia and conversion phenomena, were found in patients with panic disorder in 27%, agoraphobia - in 16%, generalized anxiety disorder - in 6% of cases [35]. Depersonalization is a kind of protective process of consciousness to neutralize severe experiences and unpleasant emotions. [36]. Depersonalization syndrome, like other psychopathological syndromes, does not have a strict nosological specificity and occurs in a wide range of disorders [37]. Depersonalization syndrome usually develops against the background of borderline or schizoid personality disorder. A.B.Smulevich, S.V.Ivanov, L.K.Myasnikova [38] note that premorbid characteristics of such patients are characterized by duality of nature (dissociation, which in the psychoanalytic literature is interpreted as a manifestation of multiple personality) and polarity of dimensional personality structure, which determines the existence of personality as if in two dimensions: in the "inner" (autism with a sense of detachment from the outside world) and "external" reality (conventional personality attitudes aimed at following social norms). It is worth noting that the presence of "duality of nature" is considered in a number of studies as one of the root characteristics of schizoid personality disorder. In the words of E. Kretschmer (1930), schizoids "distinguish between exteriority and depth"; according to P.B. Gannushkin (1933), "it is as if there are two planes in the psyche of schizoids". [39; 40] In one of the studies of Krylov V.I. et al. [41] indicates that in a group of patients with mild depressive episodes within recurrent depressive disorder (RDR) and bipolar depressive disorder (BPD), impaired self-concept was represented by depersonalization of change. As depression worsened, depersonalization of alterity acquired features common to depersonalization of loss. A directly proportional relationship of the severity of depersonalization

disorders in depressive states with the degree of mood reduction and an inversely proportional relationship with the degree of ideator inhibition was also revealed. Without strict nosological specificity, depersonalization disorders are found in a wide range of disorders. The presence of these symptoms indicates the existence of mental distress in an individual [36]. The most common taxonomies of depersonalization disorders are based on topographical and phenomenological principles. [37]. Within the framework of the clinical-pathogenetic approach it is accepted to single out as an independent phenomenon neurotic depersonalization [42], combining, as a rule, with depressive, anxious-phobic, and vegetative disturbances. The critical attitude to the condition is preserved. The manifestations are transient and reversible. Egodystonic nature of neurotic depersonalization allows some authors to approximate it with obsessive-compulsive disorder, noting the most frequent occurrence of similar symptomatology within this nosology [43; 44.]. In contrast to neurotic depersonalization, supratentorial depersonalization is phenomenologically defined by the phenomena of loss and is an extreme variant of depersonalization of alterity and alienation. Based on the principle of topographical systematics of depersonalization, according to which a three-component model of the "psychic content of personality" is assumed, in which mental processes and corporeality, as well as the surrounding world are reflected [45], three varieties of depersonalization are distinguished: autopsychic, somatopsychic, and allopsychic.Personal dissociation. Personality dissociation at the non-psychotic level of expression varies in the range from mild manifestations, which may already be at the level of constant manifestations of mental diathesis, concerning the lack of interaction between different mental functions and "splitting" of different spheres of the psyche [46], to more pronounced manifestations in the form of a polyfragmented multiple personality. The latter is a dissociation of personal identity, associated with the fact that in the case of long-term existence of unsolvable problems and interpersonal difficulties, conversion disorders determined by intrapersonal adaptation and compensatory mechanisms can last for a long time, acquiring in this case the features of dissociativity and evaluated in this case as personal development [47] with involuntary disorder or failure of the integral functioning of one or more of the following spheres: personal identity, feelings, thinking, memory, control over body movements or behavior This condition is subdivided into holistic dissociative identity disorder, coded by ICD-11 as 6B64, and partial dissociative identity disorder, coded by ICD-11 as 6B65.As part of the non-psychotic level of expression, we can also consider super valuable or nosogenic dissociative reactions, which are a catatimically charged reactive-schizoid complex [48] of disorders characterized by a combination of autistic alienation and "loss of sense of reality [49]. Minor severity: amplified level of dissociation disorder, to which, foremost, we can refer non-psychotic manifestations of autochthonous mental disorders of the schizophrenic spectrum. In contrast to non-psychotic conversion-dissociative disorders, in this case amplified conversion-dissociative phenomena are characterized by the absence of psychogenesis, "detachment" from external circumstances, as well as some features of the clinical picture and dynamics of the state, which makes it legitimate to assume that the pathogenetic mechanisms of these disorders are different from those of neurotic states and their proximity to schizophrenic spectrum disorders [50]. In this case it is noted:

1) the presence of complex connections of hysterical disorders with phobias, obsessive compulsions, vivid mastering emotionally colored ideas (about "extraordinary love", ideal relationships with the object of ecstatic attachments), outbreaks of generalized anxiety and senesto-hypochondriacal symptom complexes;

2) inertness of hysterical neurosis-like manifestations - contractures, hyperkinesias, persistent aphonia, dysphagia, writing spasm, etc. lasting for months;

3) abundant and early onset in the structure of the disease pathological fantasizing, characterized by a detached content, reminiscent of dreams or reveries and having a rough, pretentious and even ridiculous character, with a sense of encompassing, vivid visualization of scene-like fanciful representations of the patient in the eyes of others; in this case, their own fantasies are taken for reality, which leads to a series of failures and disappointments.

The same applies to the frequency of occurrence and qualitative difference of depersonalization phenomena.

According to the works of Lobkov S.A. and Sobennikova V.V., patients with schizophrenic spectrum disorders demonstrate a greater degree of depersonalization than patients with neurotic disorders [51]. Autopsychic depersonalization in patients with schizophrenic spectrum disorders according to the results of Dyakonov A.L.'s work was found in 71.88% of cases, isolated in 46.9% of cases, somatopsychic and allopsychic depersonalization were presented less frequently. In this case, depersonalization was not always consonant with the symptoms of the underlying disease; it often existed autonomously [52] and was detected at the pre-manifest stage of the psychotic disorder, remaining in the structure of psychosis, taking grotesque, exaggerated forms [53; 54; 55]. Unlike non-psychotic depersonalization-derealization disorders, the amplified depersonalization-derealization syndrome most often concerns mainly autopsychic depersonalization (in that part of it which has to do with the ideatorial form of self-consciousness). Alienation of the perception of the integrity, unity of the "I" manifests itself in the following: there is a sense of loss of ideas about the unity and boundaries of the "I", "dissolution" in the surrounding, loss of individual specificity, change in the perception of activity, manifested in the feeling of bifurcation: the patients note that they seem to have two parallel personalities, two series of mental processes are developing simultaneously. At the maximum development of the condition, patients have a feeling that they disappear, turn into "nothing", "emptiness", "point", etc. Distortion of the sense of integrity and the resulting fragmentation of perception can imitate dissociative narrowing or loss of visual fields (without a true violation of them), when patients complain of the inability to see objects in their entirety, as a result of which they have to transfer their eyes from one part of the object to another in order to examine it in its entirety [28.]. Alienation of differentiation of emotions is characterized by the emergence of a painful feeling of loss of emotions (resentment, compassion, affection or joy), loss of emotional resonance - patients subjectively experience complete insensitivity to loved ones, loss of the ability to feel pleasure and displeasure, joy, love, hatred or sadness, figuratively call themselves "living corpses". This should also include some complaints about the "loss" or "discontinuity" of the sense of time (the patient sees the movement of the hour hands, but time for him frozen in place) with the experience of immobility, lack of change. Time may seem devoid of any subjectively significant emotional content, "empty". At the same time, as noted by S. V. Tsirkin [28], in this case, despite complaints about the absence of emotions, their real safety is confirmed by the behavior of patients. Alienation of ideational forms of self-consciousness manifests itself in the fact that patients perceive themselves completely deprived of their own worldview, views, judgments, turned into faceless individuals. They find their behavior "unnatural", "feigned", which makes them "strangers among people", makes it difficult to communicate with them, alienates them. In a developed picture of autopsychic disorder, there is an objective disorder of the ability to communicate socially

In somatopsychic depersonalization there is an experience of loss of vital feelings (feeling of satiation, hunger, as if the body had dried up, life had ended). In allopsychic depersonalization, in some cases there may be a depersonalizing feeling of the presence of a stranger or "embodied awareness," in which the patient feels the same as when someone else actually looks at him or her, knowing full well that there is no one behind him or her.

Medium severity: subpsychotic level of dissociation disorder. With further generalization of dissociative disorders, the phenomena of psychic anesthesia (latin: anaesthesia psychica dolorosa) come to the fore. The feeling of insensibility is manifested, first of all, by the loss of emotional resonance. The phenomena of autopsychic depersonalization can reach the degree of complete alienation, loss of one's self. According to the same work of Dyakonov A.L. such experiences were observed in 3 patients diagnosed with schizophrenia, which corresponds to 9.3% of the total sample [52]. In some cases, dissociative subpsychotic disorders appear in the form of a change in the consciousness of the activity of the self - all actions are perceived as something mechanical, meaningless, alien. In this case, the feeling of loss of connection with others increases to the feeling of complete incomprehension of people's behavior and relationships between them.

Another form of dissociative subpsychotic disorders is a change in the consciousness of the identity of the self, and the emergence in this case of the opposition of the consciousness of the self to the external world. The patient ceases to feel himself as a person, experiences painful dependence on others - he has nothing of his own, his thoughts and actions are mechanically adopted from other people, he only plays roles, passes into images alien to himself. In this case, the expression of suicidal tendencies with attempts to realize them is noted.

In subpsychotic dissociative disorders, in contrast to psychotic depersonalization, there is no feeling of being made of one's own thoughts, actions and movements.

Significant expression: psychotic level of dissociative disorders - delusional depersonalization. The study of Basova A.Ya. [56] thesis for the degree of Candidate of Medical Sciences] of the psychopathological structure of delusional depersonalization allowed us to identify in it perceptual, ideational (cognitive), affective and behavioral components, with the help of which it was possible to analyze the structure of this syndrome. At different stages of the dynamics of delusional depersonalization, the ratio of these components was different.

In A.Y. Basova's study, the systematization of delusional depersonalization was based on the work of K. Haug (1939) [55], dividing it into auto-, somato-, and allopsychic variants. It was found that each of the variants has its own content of delusional experiences.

1. autopsychic delusional depersonalization was the most frequent (92.6% of the examined patients). It was manifested by the syndrome of doppelgangers (negative or Capgras syndrome; positive or Fregoli syndrome, as well as "own doppelgangers"), delusions of obsession.

2. Somatopsychic delusional depersonalization (41.2%) - represented by the delusion of physical reincarnation and nihilistic hypochondriacal delusion (Kotar's delusion).

3 Allopsychic delusional depersonalization (27.9%) - characterized by delusional experience of altered, unreal or absent environment. Patients are convinced that a "theater is playing out around them" (delusion of staging), they have entered a parallel world ("delusion of parallel worlds") or that the surrounding world does not exist at all (nihilistic megalomanic delusion, "delusion of the world's destruction").

In rare cases (7.0%) [56] there was total delusional depersonalization manifested by the delusion of total reincarnation and nihilistic megalomanic delusion.

When studying delusional depersonalization from the point of view of phenomenological features, we can distinguish the phenomenon of splitting, represented by delusions of obsession, doppelgangers, and parallel worlds. It consisted in the patient's sensual experience and conviction in the splitting of his mental self or the surrounding world, the separation of the mental and physical self. Based on this, we can distinguish paranoid and oneiroid depersonalization, which occurs when the experience of one's own "I" disappears [56].

Discussion

Symptoms of mental disorders are notoriously difficult to measure. Mental disorders, as well as the symptoms that constitute them, are subject only to ranking [3]. Ranking some symptom attributes (in terms of intensity of expression, severity, and duration) seems to be impractical for quantitatively comparing psychiatric symptoms with each other (considered as different objects of measurement). The dimensional approach leads to some extent to the possibility of quantifying the severity of a symptom or the degree of impairment of a particular psychological function. In this regard, there is a growing realization that psychopathology can (and should) be assessed according to its severity [57], including subthreshold symptomatology, which would allow for the identification of impairment in its initial stages. However, the disadvantage of this approach is its increased complexity and, consequently, its lower clinical utility compared with categorical classification [57], which can be overcome to some extent by identifying not only new dimensional characteristics but also a "clinician-understandable" ranking of dimensional features. Thus, the dimensional approach is useful in reflecting the true continuum of psychoses, eliminating the loss of information that occurs when categorizing data, and eliminating the high degree of overlap between currently categorically defined disorders, thereby increasing the predictive power of clinical symptoms with respect to further response to therapy, together with determining possible disease outcomes [1]. At the same time, the categorical and dimensional models of mental disorders are not antagonistic. Mutually complementing each other, they together create a unified view of the polyetiologic mechanism of mental illness development and the depth of its severity.

Dissociation, found in many nosological units, certainly requires attention and a differentiated approach in the treatment of patients. The range of severity of these manifestations can speak not only about different pathogenetic mechanisms of this condition, but also about the adaptation-compensatory potential of an individual's capabilities. At the beginning of the development of mental disorders, dissociation plays the role of psychological defense and is the best possible adaptation of the organism to the situation. But at later stages of the formation of mental disorders, when the individual's defense capabilities are exhausted, dissociation manifestations become automatic and maladaptive.

Conclusion

Due to the recent growing interest in the dimensional approach, the issue of distinguishing additional dimensions becomes relevant. Dissociative processes found in various psychiatric disorders and manifested in a wide range from neurotic to psychotic levels can aggravate the patient's clinical picture and its course, and, therefore, require additional therapeutic

interventions. Separating dissociative symptom complexes into a separate feature may contribute not only to a more detailed understanding of the mechanisms of psychiatric disorders, but also facilitate their more effective therapy.

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DOI: 10.31579/2637-8892/279