



Psychoform and somatoform dissociation, traumatic experiences, and fantasy proneness in somatoform disorders

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ABSTRACT

Many studies reported a positive correlation between self-reported traumatic experiences and self-reported dissociative symptoms. Critics postulated that this relation is mediated by the personality trait fantasy proneness. This was confirmed by a number of studies, that mainly used non-clinical samples. The present study was carried out in a clinical sample of patients with somatoform disorders ($n = 86$). Participants completed the Dissociation Experiences Scale-Revised Edition (DES-II), Somatoform Dissociation Questionnaire (SDQ-20), Traumatic Experiences Checklist (TEC) and Creative Experiences Questionnaire (CEQ). Results show that both psychoform and somatoform dissociation are moderately correlated with traumatic experiences, and that the mediating influence of fantasy proneness on the relation is negligible. It is argued that the mediating role of fantasy proneness found in previous studies may be an artefact of student samples.

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1. Introduction

The structural dissociation model (Van der Hart, Nijenhuis, & Steele, 2006) postulates a connection between medically unexplained physical symptoms, trauma, and dissociation. Symptoms such as dissociative amnesia, depersonalization, and identity fragmentation are seen as *psychoform dissociation*, whereas symptoms such as analgesia, anaesthesia, pain, and loss of motor function are referred to as *somatoform dissociation* (Nijenhuis, 2000; Van der Hart, Van Dijke, Van Son, & Steele, 2000). Somatoform dissociative symptoms are held to be physical trauma-related reactions or 'memories'. Although both types of dissociative symptoms are considered to reflect a similar mental (traumatogenic) etiology, somatoform dissociation (defined by physical symptoms) is held to be phenomenologically distinct from psychoform dissociation (defined by psychic symptoms). The validity of the construct and the alleged traumatogenic etiology of somatoform dissociation are supported by a range of studies, that found associations between somatization and somatoform disorders, psychoform dissociative symptoms, and reported trauma. Several studies suggest that somatoform dissociation, as measured with the Somatoform Dissociation Questionnaire (SDQ-20; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996), is a unique construct, related to but not completely overlapping with psychoform dissociation, and unrelated to general levels of psychopathology (Nijen-

huis, 2000; Nijenhuis et al., 1999). More in particular, somatoform dissociation has been found associated with reported trauma (El-Hage, Darves-Bornoz, Allilaire, & Gaillard, 2002; Maaranen et al., 2004; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1998; Nijenhuis, Van der Hart, Kruger, & Steele, 2004; Waller et al., 2000), and somatoform symptoms have been found often present in patients that report trauma, and in patients with dissociative disorders (Darves-Bornoz, Berger, Degiovanni, Gaillard, & Lépine, 1999; Saxe et al., 1994). Further, in studies on patients with somatoform disorders, it was found that psychoform dissociative symptoms and traumatic events are frequently reported (Roelofs, Keijsers, Hoogduin, Näring, & Moene, 2002; Salmon, Skaife, & Rhodes, 2003; Spitzer, Spelsberg, Grabe, Mundt, & Freyberger, 1999; Tezcan et al., 2003; Van Houdenhove et al., 2001; Yucel et al., 2002).

A crucial question then reads whether the correlations between reported trauma and reported psychoform and somatoform dissociation are due to experienced trauma being *causal* to dissociation. Some authors argue that a direct and causal connection between experiencing traumatic events and developing (psychoform) dissociative symptoms is evident (e.g. Herman, 1993), but others strongly disagree (e.g. McNally, 2003). Critics stress that the link between trauma and dissociation is mainly correlational, the data stemming from cross-sectional studies that use self-report measures of traumatic experiences and dissociative symptoms (Merkelbach & Muris, 2001). An exception is a longitudinal follow-up study on dissociation in adolescents who experienced traumatic medical treatment procedures in childhood (Diseth, 2006). In their

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review, Merckelbach and Muris (2001) conclude that although clinical studies show substantial correlations between measures of trauma and dissociation, modest associations are typical for college samples. In response, Näring and Nijenhuis (2005) argue that the reported modest magnitudes of the correlations may be due to the use of student samples, that typically score in a restricted range of dissociation and trauma, thus precluding the occurrence of larger associations. According to Merckelbach and Muris (2001), there is also evidence that a third variable, such as family pathology, may serve as a mediating factor in the trauma–dissociation connection (see also Nash, Hulseley, Sexton, Harralson, & Lambert, 1993). Another possible third factor may be attachment disorganization (Carlson, 1998; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). Last but not least, the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), being the most widely used measure of psychoform dissociation, overlaps with personality features such as fantasy proneness, that may compromise the accuracy of retrospective self-reports of traumatic experiences (Merckelbach & Muris, 2001).

Fantasy proneness refers to an individual trait that consists of a deep, profound and long-term involvement in fantasy and imagination, a talent for acting, along with a difficulty to differentiate imagery from real events (Lynn & Rhue, 1988; Wilson & Barber, 1983). Most fantasy prone individuals are relatively well-adjusted, but report more childhood abuse than low fantasy prone persons (Lynn & Rhue, 1988; Rhue & Lynn, 1987). Fantasy proneness may either lead to a mix-up of memories that stem from real events with those that stem from fantasies, or it may lead to the adoption of a liberal criterion for reporting past autobiographical events (Merckelbach & Muris, 2001). Possibly then, dissociation and fantasy proneness contribute to increased self-report of traumatic events, so they are not the effect but the cause of (reports of) traumatic events (Merckelbach, Horselenberg, & Schmidt, 2002). In contrast, it has been argued that fantasy proneness may be considered a coping skill for traumatized persons to escape from reality (Näring & Nijenhuis, 2005), consequently leading to the association with trauma and dissociation. A number of studies indeed reported considerable overlap between fantasy proneness and psychoform dissociation. In different student samples, dissociation and fantasy proneness were strongly and positively correlated, ranging from $r = 0.47$ to $r = 0.63$ (Merckelbach & Jelicic, 2004; Merckelbach, Muris, Horselenberg, & Stougie, 2000; Merckelbach, Muris, & Rassin, 1999; Merckelbach, Rassin, & Muris, 2000). Also, positive correlations have been found between fantasy proneness on the one hand, and trauma ($r = 0.28$; Merckelbach et al., 2002) and negative life events ($r = 0.58$; Merckelbach, Muris et al., 2000) on the other hand. Interestingly, when the contribution of fantasy proneness was partialled out, the correlation between dissociation and negative life events dropped to practically zero ($r = 0.08$; Merckelbach, Muris et al., 2000). Not only in student samples, but also in a mixed clinical sample, a positive correlation ($r = 0.55$) between fantasy proneness and psychoform dissociation has been found (Merckelbach, à Campo, Hardy, & Giesbrecht, 2005).

In sum, the causal relation between childhood trauma and dissociative symptoms is far from established. The personality trait fantasy proneness may have a substantial overlap with dissociation, and may even function as a mediator in the connection between trauma and dissociation. However, the mediating role of fantasy proneness has only been observed in one study, using a student sample (Merckelbach et al., 2002). Other studies only reported an overlap between fantasy proneness and dissociation, or used a measure of negative life events, instead of traumatic experiences, when the contribution of fantasy proneness was tested. Furthermore, only the relation between trauma and psychoform dissociation has been found to be mediated by fantasy proneness. Näring and Nijenhuis (2005) suggest that somatoform dissociation,

as measured with the SDQ-20, may be a more reliable indicator of dissociative phenomena than the DES. The present study on psychoform and somatoform dissociation was carried out in a clinical sample of patients with somatoform disorders. It was critically tested whether (1) psychoform and somatoform dissociation are correlated with reported trauma, (2) reported trauma and psychoform and somatoform dissociation are correlated with fantasy proneness, and (3) fantasy proneness functions as a mediator in the anticipated connections between reported trauma and both psychoform and somatoform dissociation.

2. Method

2.1. Participants and demographics

The sample consisted of 86 patients (72 women, 14 men) with a diagnosis of somatoform disorder, selected from a specialized psychosomatic treatment centre in The Netherlands. The age range was from 19 to 60 years (mean = 39 years, SD = 10.3). Patients that were referred to the centre volunteered to participate in the study before treatment started. All potential participants were given a complete medical evaluation to exclude medical conditions, and were diagnosed with a structured DSM-IV interview (SCID-IV; Spitzer, Williams, Gibbon, & First, 1994). Included patients had diagnoses of somatization disorder ($n = 20$), pain disorder ($n = 40$), conversion disorder ($n = 4$), pain disorder and conversion disorder ($n = 6$) and undifferentiated somatoform disorder ($n = 16$).

2.2. Instruments

Participants completed the following questionnaires:

2.2.1. Dissociative Experiences Scale

The Dissociative Experiences Scale-Revised version (DES-II; Carlson & Putnam, 1993; Cronbach α in the current study = 0.93) is a self-report measurement of the frequency of dissociative symptoms, such as amnesia, absorption, depersonalization and derealization. The 28 items are scored on a scale from 0% (*never*) to 100% (*always*), corresponding to the time that symptoms are experienced. The sum score is the mean of the different items. The DES-II produces scores very similar to those on the original version (Bernstein & Putnam, 1986).

It has been postulated that a self-report measure of psychoform dissociation taps not only pathological, but also relatively normal symptoms (e.g., Frankel, 1996; Hacking, 1995), such as absorption or absent-mindedness (e.g., Merckelbach et al., 2002). A brief, 8-item questionnaire, a subset of the 28 DES-items, has been put forward as a relatively pure measure of pathological dissociation (DES-T; Waller, Putnam, & Carlson, 1996; Cronbach α in the current study = 0.81).

2.2.2. Somatoform Dissociation Questionnaire

The Somatoform Dissociation Questionnaire (SDQ-20; Nijenhuis et al., 1996; Cronbach α in the current study = 0.76) is a self-report measure of somatoform dissociative symptoms. The 20 items are scored on a Likert-scale ranging from 1 ('this applies to me *not at all*') to 5 ('this applies to me *extremely*'). The items include positive (e.g., "I have pain while urinating") and negative (e.g., "It is as if my body, or part of it, has disappeared") somatoform dissociative phenomena. The respondent is also asked whether a physician has diagnosed the symptom as pertaining to a medical disease. In this study, all participants with medical explanations for their physical symptoms were excluded. The SDQ-20 total score is obtained by summation of the different item scores.

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