Do dissociative disorders exist in Northern Ireland?: Blind psychiatric – structured interview assessments of 20 complex psychiatric patients

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ABSTRACT – *Background and objectives:* Dissociative disorders remain relatively controversial diagnoses in British psychiatry. The aim of the current paper was to assess Northern Irish psychiatric patients with complex clinical presentations for dissociative disorders.

Method: Twenty patients meeting operationally defined criteria for psychiatric complexity were blindly assessed by a psychiatrist in a diagnostic interview followed by a clinical psychologist in a structured interview.

Results: Thirteen of the 20 participants were positive for at least one dissociative disorder. Those with a dissociative disorder had a range of co-morbid problems and all reported histories of childhood trauma and neglect.

Conclusion: The psychiatric symptom profiles of dissociative disorders in Northern Ireland are similar to those reported in the literature. Complex psychiatric presentations offer a potential diagnostic clue for such conditions.

Introduction

British psychiatry has taken a relatively conservative and somewhat sceptical view of the modern study of dissociative identity disorder (DID). This view may be considerably different to the experience of a significant number of British practitioners[1] and certainly diverges from the viewpoint of influential British clinicians and researchers working a century ago, who eagerly studied pathological dissociation (e.g.,[2], see[3]). The mental health system in Northern Ireland falls under the auspices of the British National Health Service and the training of psychiatrists and clinical psychologists is sanctioned and regulated by the Royal College of Psychiatry and the British Psychological Society, respectively. This study assessed the existence of dissociative disorders in complex psychiatric patients in Northern Ireland.

While pockets of scepticism exist in most psychiatric cultures regarding disorders like DID, a theme running through the historical dissociative disorders literature is that such conditions are not as rare as the psychiatric zeitgeist assumes. For example Prince[4] noted in an early paper on Miss Beauchamp, that "cases of multiple personality are not very uncommon…" (p. 140). Similar sentiments were echoed many years later and before the empirical escalation of interest in dissociative disorders[5]. More recent studies, presenting large cases series of individuals with dissociative disorders (e.g.,[6,7,8,9,10,11]), add scientific weight to prior clinical assertions that dissociative disorders are more common than generally assumed. Further validation of this belief comes from studies of dissociative disorder prevalence in the psychiatric (e.g.,[12,13]) and general[14,15,16] populations.

European inpatient studies show prevalence estimates for dissociative disorders of between 4.5% to 8.2%[17,18,19,20][1]. DID prevalence in these same studies ranged from .4% to 4.7%. Factors such as the detection method used (e.g., which structured clinical interview is utilised) and the nature of the inclusion criteria set for individuals who receive thorough dissociative disorders assessment, effect prevalence figures (e.g., see[21]).

Coons[22] suggests that the underdiagnosis of dissociative disorders is related to scepticism in their existence and a failure to appreciate the actual prevalence rates of these conditions. Unfamiliarity with dissociative symptoms and diagnoses is also believed to contribute to detection failure of dissociative disorders[22,23]. This latter factor may be particularly pertinent in clinical settings in Northern Ireland, as mental health professionals get little, if any, direct information on the phenomenology, prevalence, clinical characteristics and contemporary empirical understanding of dissociative disorders during training[24]. A further contributing difficulty in the detection of dissociative disorders is their often complex clinical presentations, which may include a complicated range of dissociative symptoms and other co-morbid and overlapping psychiatric and physical conditions[6,25,26,27,28]. For example, the positive or first rank symptoms of schizophrenia are typically present in DID, but may be mistaken as indicators of a psychotic illness[29,30]. Symptoms of anxiety, somatization, depression, posttraumatic stress, and various char-

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1. Research by Sar and his Colleagues in Turkey have not been cited here to limit dissociative disorder prevalence studies to those conducted nearest the United Kingdom.

acteristics of personality disorders are common in dissociative disorders[10,31,32].

Studies have begun to address dissociative disorders in Northern Ireland, and clinicians' attitudes towards them. Dorahy and Lewis[33] found that the existence of DID was generally accepted by Northern Irish clinicians (especially psychologists), but most believed the recent increase in prevalence was the result iatrogenesis and misdiagnosis, not accurate diagnosis. These explanations are consistent with viewpoints in the British[34] and Irish[35] literatures. Only a very small number of Northern Irish clinicians (n = 9) had diagnosed or been involved in the treatment of DID. In a follow-on study, most Northern Irish psychiatrists and clinical psychologists failed to detect DID in a case where discriminating and characteristic symptoms and features were overt[36].

The current study was designed to determined if DID and the other dissociative disorders actually exist in the Northern Irish psychiatric population. Psychiatric outpatients with complex psychiatric presentation were exclusively assessed using a thorough dissociative disorders assessment. Given empirical indications that dissociative disorders are not unusual in the psychiatric population, it was predicted that these conditions would be present in complex psychiatric patients in Northern Ireland.

Method

Participants

Based on the inclusion criteria outlined below (Procedure section), 21 adult psychiatric patients with no history of brain injury were identified for the study. While all agreed to take part, one withdrew, finding the assessment too emotionally taxing.

Materials

The psychiatric interview consisted of a diagnostic assessment of Axis 1 and 2 disorders and a developmental history, including experiences of life-time trauma. The structured interview assessment included the administration of the Dissociative Disorders Interview Schedule[37] as well as the completion of the Dissociative Experiences Scale[38] and the Somatoform Dissociation Questionnaire - 20 (SDQ-20,[39]).

The Dissociative Disorders Interview Schedule (DDIS) is a 132 item clinician-administered structured interview for the detection of DSM-IV dissociative disorders. Related symptoms and diagnostic categories are also assessed, including those of Schneiderian symptoms, depression, borderline personality disorder, somatoform disorder and substance abuse. A section of the DDIS also assesses childhood physical and sexual abuse history. The DDIS has displayed good sensitivity for detecting true cases of DID[40] and Kappa coefficients for detecting agreement between clinical judgement and DDIS indications of DID is over .9 (e.g.,[37]). The current study omitted the DDIS abuse history items.

The Dissociative Experiences Scale (DES) contains 28 items believed to measure both non-pathological and pathological dissociation[41]. Participants circle the percentage of time they experience each item on a scale ranging from 0% to 100%. The eight items thought to best reflect pathological dissociation (items,[3,5,7,8,12,13,22,27]) are collectively referred to as the Dissociative Experiences Scale-Taxon (DES-T,[41]). The DES has a test-retest reliability between .84 and .96 and an

internal consistency of .95[42]. Scores on both the DES and DES-T range from 0-100.

The Somatoform Dissociation Questionnaire – 20 (SDQ-20) is a 20 item self-report scale assessing somatoform dissociation. Experiences such as psychogenic anaesthesia, analgesia and loss of consciousness are appraised, along with disturbances in motor functioning and alterations in sensory perception. Items are rated along a Likert scale ranging from 1 ("this applies to me NOT AT ALL") to 5 ("this applies to me EXTREMELY"), with total scores ranging from 20 to 100. Having high correlations with psychoform measures of dissociation (e.g., DES) and an internal consistent (Cronbach's alpha) of .95, the SDQ-20 has demonstrated good psychometric properties[39,43].

Procedure

In the first instance two consultant psychiatrists (M.O'K; C.M) from the greater Belfast area assessed their adult caseload and selected patients who were deemed 'complex' based on meeting at least 2 of the following three operational defined criteria for psychiatric complexity:

– The patient had at least two different psychiatric diagnoses in their medical history.

– The patient was considered a "diagnostic anomaly": i.e., they did not "fit" one single psychiatric disorder, with their symptoms consistent with several diagnostic categories.

– The patient was "treatment-resistant" despite various interventions.

These criteria were developed from the clinical characteristics outlined in the dissociative disorders literature, especially that pertaining to DID (e.g.,[44]). Towards the end of the study two other Belfast consultant psychiatrists referred individuals who met the inclusion criteria. Participants were informed that the study was assessing the psychological experience of dissociation, and if they volunteered they would attend two interviews spaced between a week and a month apart. Both referring psychiatrists were not treating any patients for dissociative disorders before the study started. In addition, with the exception of one patient who had just been accepted by one consultant with a query of dissociative disorder in their case history, both referring psychiatrists did not knowingly have any patients with dissociative disorders on their caseloads. Before the assessment phase began key phenomenological papers in the dissociative disorders literature were distributed to all clinicians involved in the study. These included papers by Coons, Kluft, Loewenstein, Putnam, Ross, Steinberg, and Van der Hart, Nijenhuis and Steele. Following familiarity with this literature both consultant psychiatrists re-examined the diagnoses given to those referred to the study.

Participants first attended the psychiatric assessment. This assessment, conducted by a psychiatrist (HM or CT) unaware of each participant's personal and psychiatric history, provided a diagnostic work-up indicating both differential and most likely diagnoses, along with a developmental history. The structured interview assessment, conducted by a clinical psychologist (MD) who was blind to the psychiatric assessment outcome and unaware of each patient's personal and psychiatric history, involved the administration of the DDIS, the DES and the SDQ. The DES was administered at the same time as the DDIS to determine if any individuals falling under traditional DES screening cut-off scores of 20-30, were actually positive for a dissociative disorder. Both the psychi-

atric and structured interview assessments took approximately 1.5 hours.

A meeting was held at the completion of the study between the referring psychiatrists, the assessing psychiatrists and the clinical psychologist to discuss the diagnosis of each case. A dissociative disorder was not specified unless the clinical appraisal of at least 1 of the two psychiatrists involved in each case (i.e., either the patient's consultant psychiatrist, i.e., referring psychiatrist, or the assessing psychiatrist) was consonant with the structured interview indications. This strategy was deemed the most suitable means of minimising false positive diagnoses that may arise from using the DDIS in isolation[21]. Moreover, to provide the most conservative detection criteria, a DID diagnosis was only given when dissociative identities, and "switching" between them, were clearly observable during assessment.

ICD-10 is the psychiatric classification system primarily used on a day-to-day basis in Northern Ireland. Yet, all clinicians' involved in the study were familiar with the DSM system. Unlike the DSM-IV, the ICD-10 does not classify depersonalisation disorder as a dissociative disorder. Given the DDIS was used (which is based on the DSM and therefore why DSM-IV classifications were utilised), depersonalisation disorder in the current study was classified as a dissociative disorder.

Results

The 20 participants who completed the study ranged in age from 26 - 57 years (Mean = 40.7; SD = 8.8). Nineteen were female and 18 were not working at the time of the study. Twelve participants were in relationships, 3 described themselves as 'single,' 4 reported being divorced or separated and 1 participant was widowed. One participant, recently transferred from a retiring psychiatrist to one of the referring psychiatrists, indicated that dissociative disorder had been mentioned to her in the past, but she was aware of no further details or what this meant. No other participant reported a dissociative disorder in their psychiatric history.

Thirteen (65%) of the 20 assessed were positive for at least 1 dissociative disorder. The breakdown of these 13 positive cases were as follows: 1 DID, 2 depersonalisation disorder, 3 dissociative amnesia; 2 depersonalisation disorder and dissociative amnesia, and 5 DDNOS. Three individuals classified as DDNOS had strong self-report indications of DID but no switching between dissociative identities was observed during assessment. The assessing psychiatrist and clinical psychologist both independently diagnosed complex posttraumatic stress disorder for one other case, which due to the strict study criteria was not included as a dissociative disorder (and therefore was not among the 13 positive cases). On 2 of the 20 assessments, the DDIS and the clinical opinion of both the psychiatrists (consultant and assessing) did not match.

In order to present the clearest and most thorough explication of the clinical features of those meeting diagnostic and study criteria for a dissociative disorder, Table I individually presents each of the 13 dissociative cases along with co-morbid diagnoses, DDIS diagnostic indicators for the major conditions it assesses, as well as DES, DES-T and SDQ scores. For simple comparison purposes, summary and mean results for the 7 participants not positive for a dissociative disorder are included at the end of Table I. Due to the small number in this group no comparative statistics were used to assess differences

between those with a dissociative disorder and the non-dissociative group.

Table II presents the presence or absence of childhood abuse or neglect histories as well as other child and adult traumas for each dissociative participant. As in Table I, a frequency and percentage summary is provided for those with and without a dissociative disorder, for comparison purposes. Due to the small number of participants, especially in the non-dissociative disorder group, statistical comparisons were not attempted.

Table I
Dissociative and comorbid diagnoses, DDIS clinical indications and psychoform and somatoform dissociation for the individuals with a dissociative disorder (n = 13).

	Dissoc. Diag.	Co-morbid	DDIS Somat.	DDIS Sub.Ab	DDIS Dep.	DDIS FRS	DDIS BPD	DES	DES-T	SDQ
1	Amnesia	BPD-Depressive features	12 no	No	Yes	2	Yes	19.8	8.8	1.3
2	Amnesia	MDD	11 no	No	Yes	1	Yes	42.1	43.8	2.3
3	Amnesia	MDD	7 no	No	Yes	0	No	27.8	22.5	0.5
4	Deperson.	HistrionPD	18 yes	No	Yes	1	No	14.3	8.8	1.5
5	Deperson.	BPD, MDD	19 yes	No	Yes	2	Yes	34.3	13.7	3.5
6	Amnesia Deperson.	Panic/agora.	20 no	No	Yes	1	No	41.4	50	2.0
7	Amnesia Deperson.	MDD	17 no	No	Yes	0	No	37.5	16.3	1.4
8	DID		14 no	No	Yes	8	Yes	59.6	58.1	2.3
9	DDNOS		12 no	No	Yes	5	Yes	40	35	1.3
10	DDNOS	BPD; Cannabis, amphet. Abuse	14 yes	Yes	Yes	7	Yes	30.5	30	1.5
11	DDNOS	Dysthym.	17 no	Yes	Yes	1	No	27.5	21.3	1.5
12	DDNOS		19 yes	No	Yes	10	Yes	87.3	77.5	2.2
13	DDNOS	BPD	17 no	Yes	Yes	8	Yes	44.8	30	2.0
Tot. DD			15.5[1] 4/13[2]	3/13[2] 23%	13/13[2] 100%	3.5[1]	8/13[2] 62%	39.0[1]	32.0[1]	1.8[1]
Tot. Non DD.			11[1] 0/7[3]	1/7[3] 14%	7/7[3] 100%	3.3[1]	3/7[3] 43%	31.1[1,4]	23.8[1,4]	1.4[1]

DDIS Somat = DDIS somatisation subscale; DDIS Sub.Ab = DDIS substance abuse subscale; DDIS Dep = DDIS depression subscale; DDIS FRS = DDIS First Rank Symptoms subscale; DDIS BPD = DDIS borderline personality disorder subscale. Deperson. = depersonalisation disorder; BPD = Borderline Personality Disorder; MDD = Major Depressive Disorder; Amphet. Abuse = Amphetamine Abuse; Dysthym. = Dysthymic Disorder; Panic/agora. = Panic disorder with agoraphobia. Tot DD = total for those with dissociative disorder; Tot. Non DD = Total for those with no dissociative disorder. [1] = mean scores; [2] = number of positive cases as identified by the DDIS over the number of individuals with a dissociative disorder; [3] = number of positive cases as identified by the DDIS over the number of individuals without a dissociative disorder; [4] = The DES and DES-T scores for 1 non-dissociative participants, with psychotic disorder NOS were removed. This participant continued to have difficulty and misinterpreted many of the questions, despite several attempts to explain the response format.

Table II
Self-reported childhood history of trauma for the individuals with a dissociative disorder (n = 13).

	Dissoc. Diag.	Child sex. abuse	Child physical Abuse	Child emotional abuse	Child neglect	Other child trauma	Adult trauma
1	Amnesia	Yes	Yes	Yes	Yes	Yes S	Yes
2	Amnesia	Yes	Yes	Yes	Yes	Yes S	Yes
3	Amnesia	Yes	?	Yes	Yes	Yes DV, S	?
4	Deperson.	Yes	Yes	?	No	Yes DV	No
5	Deperson.	Yes	Yes	Yes	Yes	Yes DV M MI	?
6	Amnesia Deperson.	Yes	Yes	Yes	No	Yes M rape DV	?
7	Amnesia Deperson.	No	No	Yes	?	Yes	Yes
8	DID	No	Yes	Yes	Yes	Yes (DV)	Yes
9	DDNOS	No	No	Yes	Yes	Yes S	Yes
10	DDNOS	Yes	Yes	Yes	No	No	Yes
11	DDNOS	Yes	Yes	Yes	Yes	Yes S	No
12	DDNOS	Yes (stranger)	No	No	No	No	Yes
13	DDNOS	Yes	Yes	Yes	Yes	Yes DV	Yes
total		11/13 84.6%	9/13 69.2%	11/13 84.6%	8/13 61.5%	11/13 84.6%	8/13 61.5%
Non Diss.		4/7* 57.1%	3/7 42.8%	3/7 42.8%	2/7 28.5%	4/7 57.1%	2/7 28.5%

S = separation from family in childhood (e.g., adopted, parental inpatient psychiatric admission; no contact with at least one parent following separation); DV = parental domestic violence; M MI = Maternal mental illness; M rape = Mother raped; ? = unclear after questioning; * = 1 case related to rape at age 15.

Discussion

Consistent with the hypothesis that dissociative disorders would be present in the Northern Irish mental health system, over half the outpatients assessed in this study were positive for at least 1 dissociative disorder. With the exception of dissociative fugue all DSM-IV-TR dissociative disorders were evident in Northern Irish psychiatric outpatients. Whilst fugue often appears as a symptom of more complex dissociative disorders, the failure to identify discrete cases of fugue (i.e., outside cases of DID or DDNOS) is consistent with its absence in studies of dissociative disorder frequency and prevalence (e.g.,[18,45,46,47]) and is in keeping with the belief that dissociative

fugue as a stand alone diagnosis is one of the rarest dissociative disorders[22].

The high number of somatic symptoms affirmed by the dissociative disorder cohort is consistent with previous studies of dissociative individuals (e.g.,[9,10,48]). The finding that all dissociative participants had comorbid depression as indicated by the DDIS and five out of the six individuals with DID or DDNOS were positive on the DDIS for BPD is consistent with other studies. For example, using both the DDIS and the SCID-D, Horen et al.[45] found that all individuals positive for a dissociative disorder also showed DDIS indications for major depression. Moreover, three of the four individuals with DID or DDNOS in Horen et al.'s[45] study were positive for BPD. Sar et al.[49] reported a high prevalence of dissociative disorders in those meeting criteria for BPD, and BPD has been reported as a relatively common comorbid diagnosis in cases of DID[9]. Interestingly however, there was some discrepancy in the current study between BPD as indicated by clinical judgment versus the DDIS. Eight of the 13 individuals positive for a dissociative disorder showed DDIS indications of BPD, yet BPD was clinically diagnosed in only four of these cases. It seems likely that when assessed outside a full clinical picture (i.e., in isolation) BPD may be over-identified by the DDIS. This issue is pertinent in dissociative disorders as so-called borderline symptoms are common and may have a dissociative aetiology[50].

The average number of first rank symptoms reported by those with a dissociative disorder (3.5) is comparable to Sar et al.'s[46] outpatient dissociative disorder sample (4.8), which was also assessed with the DDIS. A greater percentage of individuals with DID in Sar et al.'s sample is likely to account for their slightly higher score. As can be seen in Table I, Schneiderian first rank symptoms were commonly reported by five of the six individuals with DID and DDNOS. Yet, these same symptoms were experienced considerably less by those with amnesia and depersonalisation. Averaging the first rank symptoms experienced by those with DID and DDNOS (6.5) produces a figure nearly identical to those reported in other severe dissociative disorder samples (e.g., 6.4,[10] 6.2,[48]). The similar frequency of overall first rank symptoms reported by the dissociative and non-dissociative cohorts in this study may be a product of the low number of these symptoms reported by those with amnesia and depersonalisation. In addition, the non-dissociative group included individuals with psychotic illnesses. Moreover, this non-dissociative cohort reported significant histories of childhood abuse (see Table II), which has been related to Schneiderian first rank symptoms[51]. The significant history of childhood trauma may also account for the high average DES score in the non-dissociative group.

Studies of dissociative disorder frequency and prevalence have utilized as an inclusion-exclusion screening marker a DES score of 30 (e.g.,[46]), 25 (e.g.,[45,47]) and 20[18]. However, the current study cautions against using such cut-offs in studies designed to detect dissociative disorders. Four participants with a dissociative disorder had DES scores below 30, while two were below 20. Latz et al.[52] have also demonstrated low DES scores in individuals with a dissociative disorder. Moreover, in the current study, four non-dissociative disorder participants had DES scores over 30. As well as dissociative symptoms being relatively common in many non-dissociative psychiatric illnesses, administration difficulties in psychiatric samples, as noted in one case here (See footnote in Table I), may produce inaccurate DES scores[45]. Consequently using a DES

cut-off score as a screening marker may exclude from more rigorous assessment individuals with a dissociative disorder and include those not positive for a dissociative disorder[23,53].

The current study utilized clinical rather than self-report symptom markers for thorough dissociative disorder assessment and found that well over half those assessed had a dissociative disorder. However, perhaps the most significant limitation of this method is the fact that by definition the inclusion criteria select only individuals with a significant mental illness history for thorough assessment. As a result individuals with a dissociative disorder who have only recently entered psychiatric services are excluded. Future studies may benefit from incorporating both symptom and clinical markers to identify those receiving thorough dissociative disorder assessment.

All individuals with a dissociative disorder reported some form of childhood abuse and neglect with only two of the 13 reporting no sexual or emotional abuse in their childhood. The high level of childhood interpersonal trauma in the dissociative group is consistent with findings in the literature, with large series studies report upwards of 80% of dissociative individuals with child abuse histories (e.g.,[9,54]). At the risk of error due to the small sample size, statistical comparison was not warranted. Consequently meaningful differences between abuse and neglect history in the dissociative and non-dissociative groups cannot be concluded. Yet, the data provide several observations for future followed up. Firstly, abuse and neglect did not clearly discriminate the dissociative and non-dissociative groups, suggesting a relationship between childhood trauma and complex clinical presentations. Secondly, considerably more adult trauma was reported by those in the dissociative dis-

order group, highlighting pathological dissociation as a possible risk factor for traumatic stress (e.g., [55]).

Conclusion

Idividuals with a dissociative disorder, especially DID and DDNOS, often present with a complex psychiatric picture and a history of misdiagnoses[9,28]. As such, the inclusion criteria in the current study (i.e., psychiatrically complex, treatment resistant individuals with a history of several different diagnoses) was designed to selectively increase the likelihood of including in the assessment phase individuals with an undetected dissociative disorder. Thus a representative psychiatric sample was not drawn and little comment can be made regarding the prevalence of dissociative disorders in the Northern Irish psychiatric population. However, the current results indicate that 1) dissociative disorders are a clinical reality in Northern Ireland, even if their prevalence does turn out to be relatively low, 2) complex psychiatric presentations may represent a clinical indicator which heightens suspicion for dissociative disorders, and 3) the psychiatric symptom profiles of dissociative disorders in Northern Ireland are similar to those reported in the literature.

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