

Clandestine Psychopathology: Unrecognized Dissociative Disorders in Inpatient Psychiatry

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Abstract: Surveys among Israeli mental health professionals found that almost half of them doubt the validity of dissociative disorders (DD) and have no experience in either diagnosing or treating DD patients. These findings, in line with arguments that DDs are socially construed North American phenomena, call for the need to investigate it in Israel. Eighty-one psychiatric inpatients were screened for dissociative pathology. Participants categorized as having low levels of dissociation ($n = 26$) and those demonstrating high levels of dissociation ($n = 22$) were asked to participate in a Structured Clinical Interview for the DSM—Dissociative Disorders—Revised. One-quarter of all participants were identified as having probable dissociative psychopathology. Based on the Structured Clinical Interview for the DSM—Dissociative Disorders—Revised, estimates of DD range between 12 and 21%. None of the participants had any indication of a DD diagnosis in their medical records. Diagnosis of personality disorder and psychiatric comorbidity were related to the likelihood of a DD diagnosis and its severity.

Key Words: Dissociative disorders, psychiatric inpatients, childhood maltreatment.

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Despite the accumulation of supportive evidence, the diagnosis of dissociative disorders (DD) is still controversial. Surveys among mental health professionals revealed that almost half of them regard DD as dubiously valid, or invalid, disorders (Leonard et al., 2005). Thus, it is not surprising there are indications that DDs are underdiagnosed in psychiatric care. That is, although systematic screening among psychiatric patients revealed that a considerable proportion of patients, ranging between 4 and 29%, meet the diagnostic criteria for DD (e.g., Foote et al., 2006; Gast et al., 2001), most of those who were diagnosed by the research staff with DD (79%–84%) did not have a dissociative diagnosis recorded in their clinical files (Foote et al., 2006; Mueller et al., 2007).

There is only scarce evidence regarding the actual diagnoses received by undetected DD patients. There are indications that many may have received multiple diagnoses (Tutkun et al., 1998), possibly reflecting either real comorbidity or clinicians' uncertainty. The few studies that traced the clinical records of DD patients indicated that affective disorders were the most prevalent disorder diagnosed by their therapists (Tutkun et al., 1998). However, the validity of the diagnosis of affective disorder turned out to be questionable in light of reports of relatively low levels of dissociation among individuals with affective disorders (Putnam et al., 1996).

A large scale survey among mental health professionals in Israel found that 63% of those interviewed had no experience either diagnosing or treating DD patients (Somer, 2000). These findings, ostensibly in line with arguments that both the diagnosis and its manifestations are socially construed North American phenomena (see Spanos, 1994), call for the need to investigate the validity of DD in Israel. This study reports the results of screening for DD among Israeli psychiatric inpatients.

METHODS

Study Design

A two-stage methodological approach common to DD prevalence studies was employed (e.g., Tutkun et al., 1998). The first stage involved an initial screening of the target population by a self-report questionnaire. In the second stage, a structured clinical interview was conducted with available individuals who scored above a cutoff point considered indicative of probable dissociative pathology. For comparison purposes, we also included a group of participants who scored below a cutoff point indicating the probable absence of DD. Another advantage of the current study relates to the screening instrument employed. Many previous studies used the Dissociative Experiences Scale (Bernstein and Putnam, 1986) for screening purposes, which in addition to the assessment of pathological dissociation, also assesses manifestations of normative dissociation, such as absorption and imaginative involvement. In the current study, we used an extensive screening tool that focuses exclusively on dissociative pathology.

Participants and Data Collection

Ninety-six psychiatric inpatients who did not have an appointed legal guardian, hospitalized for at least 1 week in acute wards of 2 psychiatric hospitals, were approached by the research staff. Eighty-one (84%) patients consented to participate in the study (stage 1). In the second stage, inpatients who were categorized as having low levels of dissociation [Multidimensional Inventory of Dissociation—Hebrew Version (H-MID) scores ≤ 10 ; $n = 26$] and those demonstrating high levels of dissociation (H-MID scores ≥ 30 ; $n = 22$) were invited to participate in a *Structured Clinical Interview for the DSM—Dissociative Disorders—Revised* (H-SCID-D-R) interview. Some of these patients were discharged by the time of the second stage, whereas others refused to be interviewed. Twenty-three participants (10 low dissociators and 13 high dissociators) were eventually interviewed in the second stage. A series of comparisons indicated that stage 2 participants and dropouts did not differ in age, gender, level of education, history of childhood maltreatment, onset age of the mental health disorder, or number of hospitalization.

Fifty-nine percent of the participants were men. Participants' age ranged between 18 and 65 years [mean (M) = 34.18, standard deviation (SD) = 11.3]. Most were single (61.7%), the rest were either married (12.3%) or separated/divorced (25.9%). Half the sample had 12 years of education (51.9%), 28.4% had fewer years of education, and the rest (19.8%) completed >12 years of education. Most of the inpatients were unemployed during data collection (69.1%).

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One half of the sample (55.6%) carried a diagnosis of schizophrenia, and the records of one-third (34.5%) indicated an affective disorder. Fourteen percent of the patients were diagnosed as having a personality disorder, with or without a comorbid disorder. Eighty-five percent had a single psychiatric disorder, and the rest (14.8%) carried 2 or more concurrent diagnoses. During data collection, patients had been hospitalized for an average of 4.61 weeks ($SD = 4.12$). Mean number of previous hospital admissions was 4.34 ($SD = 4.82$).

The study was undertaken after institutional Helsinki committees approved the research design. Informed consent was obtained from all participants before data collection.

Instruments

Biographical variables: Data regarding gender, age, marital status, number of years of education, and occupation were gathered through self-report questionnaires. Data on psychiatric diagnosis, number of admissions, and length of current hospitalization were collected from medical records.

Childhood maltreatment was assessed by The Child Trauma Questionnaire (Bernstein et al., 1994). This self-report measure assesses childhood maltreatment history, manifested as emotional abuse or neglect, physical abuse or neglect, and sexual abuse.

The Child Trauma Questionnaire has been demonstrated to have strong psychometric properties in both clinical and community samples (Bernstein et al., 1994). Alfa Cronbach in the current sample was 0.84, demonstrating good internal consistency.

Dissociative symptoms were assessed by the H-MID. This self-report inventory, developed by Dell (2006), was translated into Hebrew and validated by Somer and Dell (2005).

The inventory is comprised of 168 dissociation items and 50 validity items. Respondents are asked to indicate how often they experience each symptom when not under the influence of alcohol or drugs. Total score ranges between 0 and 100. A score of 30 and above is considered a cutoff mark indicative of probable dissociative psychopathology, whereas a score of 10 and below is considered an indication of a low level of dissociation (P.F. Dell, personal communication, 2008).

Previous studies demonstrated strong psychometric properties (Dell, 2006; Somer and Dell, 2005). Alfa Cronbach in the current sample was 0.99, indicating excellent internal consistency.

The Structured Clinical Interview for DSM-IV Dissociative Disorders—Hebrew version (H-SCID-D-R), developed by Steinberg et al. (1990), was translated to Hebrew by Somer et al. (2001). The SCID-D is reported to have a high discriminant validity and inter-rated reliability ($\kappa = 0.88$; Steinberg et al., 1990) and is considered a gold standard for the assessment of DDs. This interview assesses DDs, according to DSM-IV-TR criteria and provides severity ranking of the identified dissociative pathology. The third and fourth authors, licensed clinicians and graduate students, received 5 hours of training and ongoing supervision by the second author (E.S.) on the administration and scoring of the H-SCID-D-R.

RESULTS

Dissociative Symptoms and Psychopathology

Twenty-two participants (27.2%) scored at, or above, an H-MID cutoff mark indicative of probable dissociative psychopathology. Forty-one percent ($n = 33$, 40.7%) were classified as having a moderate level of pathological dissociation, and approximately one-third ($n = 26$, 32.1%) scored at the lower end of the dissociation severity spectrum.

Of the 13 high dissociators who were interviewed in the second stage, 10 (77%) were diagnosed with the H-SCID-D-R, as suffering from a DD: 1 was diagnosed as having a depersonalization

disorder, 1 was identified as DID, and 8 patients were assessed as suffering from dissociative disorder not otherwise specified. None of the low dissociators was diagnosed as having DD. Thus, there was a considerable agreement between H-SCID-D-R diagnoses and H-MID categorization ($\chi^2 = 13.6$, $p < 0.001$, $\phi = 0.77$). Similarly, a strong association was found between the severity of dissociative pathology as was estimated by the H-MID, and H-SCID-D-R ($r = 0.63$, $p < 0.05$).

Dissociative Symptoms and Psychiatric History

Examination of the patients' psychiatric records revealed that none of the 10 diagnosed DD patients had been previously identified as suffering from any dissociative psychopathology. The most prevalent disorder in the sample's psychiatric records was affective disorder (6), followed by personality disorder (5), schizophrenia (3), adjustment disorder (1), and substance abuse disorder (1). Four of the DD patients carried a single psychiatric diagnosis whereas the records of the 6 newly diagnosed DDs indicated a concurrent diagnosis of >1 psychiatric disorder.

Severity of dissociative symptomatology as measured by the H-MID was not associated with existing psychiatric diagnosis. More specifically, inpatients diagnosed with schizophrenia did not differ in their mean H-MID score from those with affective disorders [$t(71) = 1.8$, n.s.]. Severity of dissociative symptoms was, however, associated with an existing psychiatric diagnosis of a personality disorder. That is, inpatients carrying a diagnosis of personality disorder (with or without another comorbid diagnosis) scored higher on the H-MID ($M = 39.07$, $SD = 13.75$) compared with those who were not seen as personality disordered [$M = 17.47$, $SD = 16.54$; $t(79) = 4.11$, $p < 0.05$].

Severity of dissociative symptomatology was also associated with the number of comorbid psychiatric diagnoses assigned to the patient. That is, patients whose records specified 2 or more concurring psychiatric diagnoses had higher levels of pathological dissociation ($M = 45.18$, $SD = 16.45$) than those who had received a single psychiatric diagnosis [$M = 15.3$, $SD = 13.06$; $t(79) = 7.4$, $p < 0.001$].

Finally, neither number of previous psychiatric hospitalizations nor onset age of the mental health disorder was associated with severity of dissociative symptoms ($r = 0.06$, n.s.; $r = -0.05$, n.s., respectively).

Biographical Data and Dissociative Symptoms

Linear regression was conducted to examine the unique and cumulative contribution of patients' biographical data (gender, age, and childhood maltreatment), current psychiatric comorbidity (having at least 2 concurring diagnoses), and the interactions of childhood maltreatment with age, gender, and psychiatric comorbidity to the variance of pathological dissociation. Z scores were computed for all variables.

The regression model explained 40% of the variance of dissociative psychopathology [$F(7,80) = 7.71$, $p < 0.001$]. Childhood maltreatment ($\beta = 0.31$; $p < 0.01$), psychiatric comorbidity ($\beta = 0.40$, $p < 0.01$), and the interaction between age and childhood maltreatment ($\beta = -0.30$, $p < 0.01$) made a significant contribution to the explained variance of dissociative psychopathology. An inverse relationship between childhood abuse and dissociative psychopathology was identified: the more severe the childhood maltreatment, the higher the reported dissociative psychopathology, and inpatients identified as suffering from a single psychiatric disorder endorsed lower levels of dissociative symptomatology than those with multiple diagnoses.

To explore the specific nature of the interaction, a median split analysis was conducted for age (median = 32), and respondents

were categorized into 2 age groups (32 years old or younger, and older than 32 years). Pearson correlations indicated a significant correlation between childhood maltreatment and dissociative psychopathology among the younger ($r = 0.58$, $p < 0.001$) but not among the older participants ($r = 0.19$, n.s.).

DISCUSSION

About one-quarter of the participants were identified with a probable dissociative psychopathology. H-SCID-D-R with available eligible patients identified 12% of the entire inpatient sample as having a DD. Based on the high agreement between H-SCID-D-R diagnoses and the H-MID categorization, it is plausible to assume that rates of DD in the complete sample were actually higher, probably closer to 21%. The fact that these incidence rates are similar to those reported in other studies (e.g., Foote et al., 2006; Mueller et al., 2007), supports the validity of the DD and is inconsistent with arguments that DDs reflect socially construed North American phenomena (see Spanos, 1994).

Similar to previous reports (Foote et al., 2006; Mueller et al., 2007), none of the psychiatric inpatients diagnosed as DD had a prior indication for this diagnosis in their clinical records. Despite the growing body of evidence supporting the validity of DDs, these patients continue to be under- or misdiagnosed, under- or mistreated, and insufficiently respected (Spiegel, 2006). Various causes may explain this troubling reality. First, the inability of many DD patients to express their internal experiences can be explained by their habitual silence acquired during years of hiding their secret of abuse, and by their motivation to present a healthier appearance to conceal their chaotic internal life (Spiegel, 2006). Another explanation for the underdiagnosis of many of our respondents might be found in clinicians' skepticism, lack of awareness, or poor diagnostic skills (e.g., Somer, 2000). Misperceptions regarding the rarity of these disorders (Leonard et al., 2005) and clinicians' reluctance to recognize and interact with the horrific results of abuse and the demanding complexity of these disorders (i.e., Perlman, 1995) may lower clinicians' motivation to acquire the necessary knowledge and skills. Finally, underdiagnosis of DDs may also be associated with problematic diagnostic criteria. Although DSM-based criteria require external and observable symptoms, most dissociative phenomenology is internal and subjective (Dell, 2009). The most prevalent DD in our study was the unspecific dissociative disorder not otherwise specified. This finding, in line with previous reports (e.g., Sar et al., 2007), illustrates the inadequacy of the current DD taxonomy and supports arguments favoring revision of the DSM diagnostic criteria of DDs (see Dell, 2009).

Consistent with previous findings (Tutkun et al., 1998), we found that the diagnosis of DD and the severity of dissociative symptomatology are strongly associated with the existence of psychiatric comorbidity. That is, patients whose records specified 2 or more different psychiatric diagnoses had higher levels of pathological dissociation compared with patients who had received a single psychiatric diagnosis. This finding could reflect the complex consequences of exposure to massive trauma. Previous findings demonstrate the high prevalence of dual and triple comorbidity among survivors of traumatic events (Ginzburg et al., in press). Alternatively, these findings may, again, expose clinicians' difficulties in recognizing DDs, as manifested in their attempts to describe their patients' complex or unusual clinical picture by a combination of more familiar diagnoses.

The association of dissociative psychopathology with a reported history of childhood maltreatment, a theorized etiological idea, renders further construct validity to the phenomenon of DDs, in line with findings reported by others (e.g., Foote et al., 2006;

Tutkun et al., 1998). The weaker effect of childhood maltreatment among older patients may be a possible result of decreasing dissociative experiences with age (Maaranen et al., 2008) and some post-traumatic adaptation that may have occurred over time.

The findings of this study should be considered in light of its limitations. The most salient weak point is the modest sample size and rate of participant attrition. Although response rate was satisfying in the first assessment, due to hospital discharge only half of the subsample that was screened to participate in the second assessment was allocated and consented to participate. Although participants and dropouts did not differ in their demographic characteristics, exposure to childhood maltreatment, or psychiatric history, the possibility of selective attrition cannot be completely ruled out.

The findings of the study imply that dissociative disordered patients hospitalized for psychiatric care might not be accurately diagnosed and consequently might not receive optimal care. There is evidence that most DD patients spend >3 years in the psychiatric system and one-third of these see 6 or more clinicians before a DD diagnosis is made (Leonard et al., 2005). In light of the adverse consequences of misdiagnosis, in general, and among the chronically traumatized, in particular, the findings of the current study stress the critical need for quality DD diagnostic training among mental health professionals.

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