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An outpatient clinical study of dissociative disorder not otherwise specified

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Abstract

The relatively high prevalence of the diagnosis of dissociative disorder not otherwise specified is frequently considered to be disproportionate. The disproportionate rate of this diagnosis is thought to be related to nosologic and/or diagnostic issues in dissociative identity disorder. We sought to investigate and compare the symptom patterns of these two clinical entities. We conducted a cross-sectional study involving 1314 participants who were screened with the Dissociative Experience Scale (DES) and the Somatoform Dissociation Questionnaire (SDQ). Of the participants, 272 who scored above the cut-off points for the screening questionnaires (DES score > 30 and/or SDQ score > 40 points) were invited to complete a structured interview using the Dissociative Disorders Interview Schedule (DDIS); of this subsample, only 190 participants agreed to participate in the second phase of the study. The mean score for the DES was 18.55 ± 17.23, and the mean score for the SDQ was 30.19 ± 13.32. Of the 190 participants, 167 patients were diagnosed as having a dissociative disorder (87.8%). We found that DD-NOS was the most prevalent category of dissociative disorder.

There was a significantly larger percentage of patients in the DID group than in the DD-NOS group according to secondary features of DID and Schneiderian symptoms. The secondary features of DID and Schneiderian symptoms appeared to be more specific for DID, while no differences were detected between DID and DD-NOS based on most of the items on the SCL 90R. Further longitudinal studies are needed to determine the features that are similar and dissimilar between DD-NOS and DID.

1. Introduction

Epidemiologic studies on dissociative disorders have revealed prevalence rates of above 10% among psychiatric inpatients and outpatients and a rate of 35.7% in patients of emergency services in Turkey [1,2]. According to both clinical and epidemiological studies [1,3–5], the most common diagnosis of the dissociative disorders (DD) in both clinical and non-clinical settings is dissociative disorder not otherwise specified (DD-NOS), with a prevalence rate of approximately 40% [6,7]. The high prevalence rate of DD-NOS is frequently observed as disproportionate for DD in the literature. The relatively high proportion of DDNOS is usually considered to be a consequence of nosologic and/or diagnostic issues related to dissociative identity disorder (DID) [8,9], and this issue hypothetically lies within the boundary DD-NOS and DID [6]. However, DDNOS is a more heterogeneous diagnostic category than DID and requires a clarification of the criteria that define it [6], which is problematic [9]. Proposed reason for the extended period of time needed for a correct diagnosis in DID is the high rate of comorbid non-dissociative symptoms that may mask the core dissociative symptomatology [10]. In this study, we hypothesized that there was no difference between DD-NOS and DID based on clinical symptomatology. We aimed to investigate and compare the symptom patterns of DD-NOS and emerge differences/similarities between DD-NOS and DID based on Schneider's First Rank Symptoms, Secondary Features and Extrasensory Experiences, as well as the Symptom Check List 90 Revised (SCL-90-R).

2. Methods

Our study was conducted among patients who attended our outpatient clinic over the course of nine months

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(01.12.2010–01.09.2011). The study design was cross-sectional in nature, and 2000 participants were taken into consideration naturalistically after obtaining informed consent from the patients and excluding patients who did not meet the appropriate study criteria. Patients were excluded if they met the DSM-IV TR criteria for schizophrenia, schizoaffective disorder, mental retardation, or severe pathology preventing collaboration, organic mental disorders, and physical-handicaps (i.e., being blind). A total of 534 patients were excluded from the study because they met the exclusion criteria. In the first phase of the study, the Dissociative Experience Scale (DES) and the Somatoform Dissociation Questionnaire (SDQ) were given, and participants' phone numbers were collected. A total of 152 patients refused to complete these questionnaires. The remaining participants (n = 1314) were then included from the study. After the screening period, all participants whose test scores were above the cutoff point (DES > 30 and/or SDQ > 40) were invited to engage in a structured interview using the Dissociative Disorders Interview Schedule (DDIS). Of the 1314 participants who completed the DES, there were 272 participants (20.70%) with scores above the cutoff. Although five of the participants refused to complete the SDQ, there were 202 participants (15.43%) whose scores were above the cutoff. In the second phase of the study, we aimed to obtain a total of 272 participants whose test scores were above the cut-off scores for the DES and SDQ but we could reach by phone number 190 of them (190 in 272 participants, 69.8%). In addition, the revised version of the Symptom Check List 90 (SCL-90-R) was given as a Symptom Check List in this phase. In the second phase, the DES score in one case was also above the cutoff point, while the SDQ was not completed during the screening phase. The DDIS was applied by the same resident who was educated by Professor Dr. Vedat SAR in Istanbul University, an expert in dissociative disorders, during the second phase of the study.

3. Assessment instruments

3.1. Sociodemographic form

A brief sociodemographic form was created for this study. The form evaluated the age, education level, psychiatric history of participant and family, first symptoms at the point of initial psychiatric attempt, history of suicide attempt, psychophysiological function, income, marital status, and gender of the participants.

3.2. Cultural questions

In Turkish culture, patients attempt to define psychiatric illness in terms of being effected by 'jinn' cultural form of possession. Because patients often link their psychiatric disorder with jinn, we asked our participants whether they believe in jinn and if they felt that jinn were responsible for their illnesses. *Dissociative experience scale (DES):* The Dissociative Experiences Scale (DES) is a 28-item self-reporting instrument that was developed by Bernstein and Putnam [11]. DES is not a diagnostic tool; rather, it is a screening test for DD with possible scores ranging from 0 to 100. The Turkish version of this scale has good reliability and validity [12] and among general psychiatric patients the cutoff score was determined to be 30 points [13].

3.3. The Somatoform Dissociation Questionnaire (SDQ)

The SDQ, which was developed by Nijenhuis et al. [14], is a 20-item self-report instrument that assesses the severity of somatoform dissociation. In Turkish samples, patients with test scores above 40 points have an increased risk of DD [15].

3.4. The Dissociative Disorders Interview Schedule (DDIS)

DDIS is a 131-item structured interview used to evaluate the DSM-IV diagnoses of somatization disorder, major depression, borderline personality disorder, alcohol and drug abuse, and the five DSM-IV dissociative disorders [16]. It is also used to inquire about a wide range of other experiences, such as trauma history, and about features thought to be associated with DID, such as Schneiderian symptoms. It has been found to have good inter-rater reliability (kappa = 0.68). The false positive rate is less than 1% for the diagnosis of DID. The DDIS has good concurrent validity with the DES and the Structured Clinical Interview for DSM-IV dissociative disorders [16]. In Turkey, the DDIS reveals a symptom pattern for DID that is quite similar to that noted in North American studies [17]. Yargıc et al. have reported Turkish validity and reliability [13]. In the Turkish version of the DDIS, two items regarding childhood emotional abuse and neglect items were combined, which is not the case in the English version [13].

3.5. The Symptom Check List 90 (SCL-90-R)

The SCL-90R is a 90-item, self-report clinical rating scale that is widely used to measure current psychopathology [18]. In addition to a global rating (Global Severity Index), it consists of nine subscales, which are as follows: somatization, obsessional compulsion, interpersonal sensitivity, depression, anxiety, anger–hostility, phobic anxiety, paranoid ideation, and psychoticism. The reliability and validity of the Turkish version of the SCL-90R produced similar results to those of the original version [19].

3.6. Statistical analyses

The software program, SPSS, version 16.0 (SPSS Inc. Chicago, Illinois, USA), was used to evaluate the results. Categorical variables were compared with chi-square tests, and, if the expected value in any cell of the two-by-two table was less than 5, the Fisher's Exact Test was used. Continuous variables were compared using the Mann Whitney-U and one-way ANOVA tests. For all statistical