Dissociative pathology discriminates between bipolar mood disorder and dissociative disorder

Sir: Although dissociative identity disorder (DID) is a prominent diagnostic category in DSM–IV, serious doubt has been voiced in this journal about the validity of this diagnosis (Fahy, 1988; Merskey, 1992). Merskey suggested that so-called dissociative symptoms may be a misinterpretation of bipolar disorder. From this criticism a specific hypothesis can be derived: high scores on instruments measuring dissociative pathology should be typical not only of patients with the diagnosis of dissociative disorder, but also would be found in patients with bipolar disorder.

In order to study this question, we administered the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) and the Somatoform Dissociation Questionnaire (SDQ–20; Nijenhuis *et al*, 1996) to patients with bipolar mood disorder (n=51), DID (n=21) or dissociative disorder not otherwise specified (DDNOS; n=20). The DES measures dissociative symptoms, such as dissociative amnesia and identity fragmentation (scores range from 0 to 100). The SDQ–20 measures somatoform manifestations of dissociation, for example, loss of control over sensation and movement (scores range from 20 to 100). The bipolar mood disorder patients were recruited from two mood disorder clinics. The dissociative disorder patients were assessed with the Structured Clinical Interview for Dissociative Disorders (SCID–D; Steinberg *et al*, 1993).

Bipolar mood disorder was associated with low dissociation scores (DES: 11.6 (s.d.=9.8); SDQ–20: 22.9 (s.d.=3.7)), DDNOS with significantly higher scores (DES: 38.6 (s.d.=14.3), t=9.12, 69, P<0.0001; SDQ–20: 42.5 (s.d.=12.0), t=7.14, 20.40, P<0.0001), and DID with extreme dissociation (DES: 54.9 (s.d.=14.5), t=−3.61, 39, P<0.001; SDQ–20: 55.6 (s.d.=14.0), t=−3.19, 39, P<0.003).

The DES is also a dissociative disorder screening instrument, as is the SDQ–5 (Nijenhuis *et al*, 1997, in press), which consists of five SDQ–20 items. Only 10% (DES) and 4% (SDQ–5) of the bipolar mood disorder patients obtained scores above the cut-off values of these instruments, but 80 and 75% of the DDNOS patients, and 100 and 97% of the DID patients passed the cut-off values.

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One hundred years ago

Asylum reports for 1896 – Glasgow Royal Asylum, Gartnavel

During the year 1896 there were 112 admissions, 41 recoveries, and 31 deaths. Brain diseases were, as usual, by far the most frequent cause of death. The mean age at death was fifty-four years. Dr Yellowlees is of opinion that the apparent increase of insanity is due to the fact that many brain conditions – such as imbecility, senility, and childishness following paralysis – which were not formerly regarded as insanity are now classified under that category. His conclusions regarding the prospect of recovery in insanity, omitting cases of imbecility or of mere senility, are broadly stated thus: Of twelve persons attacked by insanity, one half will recover and the other half will not recover; of the six who recover, one half will remain permanently well, while the other half will become insane again once or oftener in the course of their lives, and will eventually die insane. This is in accordance with the views expressed by the late Dr Hack Tuke after a minute study of available statistics. The Commissioners state that the asylum is conducted with great ability and that it well deserves the confidence of the public.

REFERENCE

Lancet, 3 July, 1897, 29.

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Corrigenda

Harrison, P. J., *BJP*, 170, 298–300. In the first column of Table 1, p. 298, the first point ('Infectivity survives cooking') should have been at the bottom of the list.

Harrison, P. J., *BJP*, 170, 298–300. Lines 10–12 of the second paragraph on p. 300 should read, '. . . the corruption of endogenous PrP molecules . . .'.

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