Abstract

People with pathological dissociation should receive proper clinical attention and timely support. Recent studies have shown that pathological dissociation is common in the Chinese context. However, little is known about the clinical features of Chinese people with pathological dissociation. This paper reports the first data regarding trauma histories, mental health symptoms, clinical diagnoses, service usages, stigma and psychosocial needs in a convenience sample of Chinese people who screened positive for pathological dissociation on a self-report measure (N = 72). This sample was characterized by a history of trauma and high levels of trauma-related symptoms and depression. Medication treatments were the most common interventions for them; many participants did not receive psychotherapy. We found no clinical differences between participants who had and had not received psychotherapy for post-traumatic/dissociative symptoms. This implies that many participants did not have the chance of receiving specific psychotherapy even though their trauma histories and clinical symptoms were as severe as those who were receiving specific psychotherapy. Stigma and unmet psychosocial needs were common in this sample and should receive more attention in the field. Implications for research and practice are highlighted. More dissociation-informed services are required for Chinese-speaking populations.

Keywords: Dissociation; Dissociative disorders; Mental health; Social work; Psychosocial needs; Cross-cultural psychiatry

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Clinical features of a Chinese sample with self-reported symptoms of pathological dissociation

Hong Wang Fung, MSS, RSW

The Department of Applied Social Sciences, The Hong Kong Polytechnic University, Hung Hom, Hong Kong

Chitat Chan, PhD

The Department of Applied Social Sciences, The Hong Kong Polytechnic University, Hung Hom, Hong Kong

Colin A. Ross, MD

The Colin A. Ross Institute for Psychological Trauma, Richardson, Texas, United States

Edward K. S. Wang, MS, PsyD

Massachusetts General Hospital, Harvard Medical School, Boston, Massachusetts, United States

Correspondence concerning this article should be addressed to Hong Wang Fung, Contact: andyhwfung@gmail.com

Dissociation, which refers to a failure in the process of integrating certain normally accessible biopsychosocial experiences (e.g., memories, emotions, identities) within one's personality, is an officially recognized mental health problem in DSM-5 and ICD-11 (American Psychiatric Association, 2013; World Health Organization, 2018). Dissociative phenomena in these diagnostic systems typically refer to those experiences that are "pathological", either by causing significant distress or leading to impairments, and are not culturally normal. Once believed to be uncommon, dissociative disorders (DDs) reportedly have a prevalence of about 10% in the general population across different cultures (Kate, Hopwood, & Jamieson, 2020; Şar, 2011). Dissociation can be regarded as a spectrum of phenomena and is a major feature of traumatization, and therefore it also commonly affects trauma survivors (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996) and patients with other trauma-based disorders, such as complex post-traumatic stress disorder (PTSD) and borderline personality disorder (BPD) (Van der Hart, Nijenhuis, & Steele, 2006). Some examples of pathological dissociative symptoms, as suggested by Dell (2009) and operationalized on well-established measures such as the Dissociative Experiences Scale-Taxon (DES-T) (Waller, Putnam, & Carlson, 1996), include the following: amnesia, depersonalization, hearing voices from a dissociated personality state, and identity alteration. People with pathological dissociation should receive proper clinical attention because they typically require specific trauma- and dissociation-informed interventions (Brand, Classen, McNary, & Zaveri, 2009; Brand & Webermann, 2015). Even among patients with nondissociative disorders and patients who do not fully meet the diagnostic criteria for a dissociative disorder, pathological dissociation still requires attention because it may lead to a poor response to general treatment (Bae, Kim, & Park, 2016). For example, in patients with depression, the occurrence of pathological dissociation indicates higher needs for psychosocial care (see the concept of dissociative depression) (Fung & Chan, 2019; Şar, 2015); in patients diagnosed as having schizophrenia, pathological dissociation may also indicate an etiologically different subgroup that requires dissociation-informed psychotherapy (see the theory of a dissociative subtype of schizophrenia) (Ross, 2004, 2009).

As a cross-culturally occurring mental health problem, pathological dissociation has been reported in the Chinese context. As early as in 1990, Ross (1990) mentioned seeing a woman with

classical dissociative identity disorder (DID) born in Hong Kong. A pioneer study in Shanghai reported that DDs were less common in their samples (N = 1,345 in total) than in North American samples – only 1.7% of psychiatric inpatients, 5.0% of outpatients and 0.3% of factory workers had a DD on a structured interview (Xiao et al., 2006). A subsequent Shanghai study of inpatients diagnosed with schizophrenia (N = 96), however, reported that 15.3% of participants had a DD on a structured interview (Yu et al., 2010). There is also a conference paper reporting 72 cases with DID in Taiwan (Chang, 2008), along with some single case reports of DID from Taiwan and Hong Kong (e.g., Fung, 2016; Hung & Chen, 2008). A paper also described the phenomena of pathological dissociation in the ancient Chinese medicine literature (Fung, 2018). More recent studies have developed Chinese versions of dissociation measures (Chan, Fung, Choi, & Ross, 2017; Fung, Choi, Chan, & Ross, 2018) and indicated that dissociative symptoms and disorders are also common among Chinese people – studies using self-report data from a Hong Kong college student sample found that 4.52% of participants had a probable DD and 17.4% of participants reported 3 or more DID features (N = 177 and N = 190) (Fung, Ho, & Ross, 2018; Fung, Ling, Ross, Tse, & Liu, 2020); another study in a sample of Hong Kong mental health service users (N = 202) found that 14.4% of participants screened positive for a DD (Fung, Ross, Yu, & Lau, 2019). A more rigorous Taiwan study using structured interviews showed that 19.5% of participants had a DD in a sample of acute psychiatric inpatients (N = 87) (Chiu et al., 2017). This literature shows that the rates of a (probable) DD may range from 0.3% to 4.52% in nonclinical Chinese populations and 1.7% to 19.5% in clinical Chinese populations. The rate of Chinese people suffering from symptoms of pathological dissociation – including those who have dissociative symptoms (e.g., flashbacks, depersonalization) but not a full DD – would be even higher.

Although the cultural context of trauma recovery is important (Bryant-Davis, 2019), to our knowledge, no study has systematically investigated the clinical features of Chinese people with pathological dissociation, including their trauma histories, mental health symptoms, clinical diagnoses, treatment usages, psychosocial needs and stigma. Such data are important because this could help recognize the importance of addressing the needs of Chinese people with pathological dissociation, provide insights for developing specific services for this underserved population, and increase the

cross-cultural understanding of dissociation. Therefore, this paper reports the clinical features of a convenience sample of Chinese people who screened positive for pathological dissociation and highlights the implications for research and practice.

Methods

We analyzed data from an intervention study that evaluated a web-based psychoeducation program for Chinese-speaking people who reported symptoms of pathological dissociation. This study was approved by The XXXX Human Subjects Ethics Sub-committee. During the period from February to April 2020, using a convenience sampling approach, we recruited Chinese-speaking people who self-reported suffering from dissociation through both online and offline channels – in particular, we advertised the program and shared the recruitment information on social media platforms. We also sent the recruitment poster to local service providers and invited them to share this resource with their service users. Potential participants were told that they could access a web-based psychoeducation program and that participants who completed the research process would be automatically entered into a sweepstakes (12 randomly selected participants would win a Supermarket Coupon valued at HK$1500). They needed to give informed consent and complete an online screening survey (Time 1) in order to participate. To ensure the validity of the data, we conducted a brief mobile phone-based interview (e.g., phone, WhatsApp, Line) with each participant to confirm their identities after they completed the screening survey. As it was a single-group pretest-posttest study with a double pretest design, participants who had confirmed their identities were invited to complete another online survey (Time 2) in mid-April 2020.

In the present study, only participants who were aged 18 or above and scored above the recommended cutoff of 27 on the Chinese version of the Dissociative Experiences Scale-Taxon (DES-T) (Fung, Choi, et al., 2018) (to ensure that they suffered from pathological dissociation) in the screening survey were included for analysis. Participants who did not confirm their identities in the briefing interview were excluded.

Measures

In the screening survey, in addition to questions regarding demographic backgrounds and service usages, participants completed several self-report measures, including:

The Dissociative Experiences Scale-Taxon (DES-T), which is an 8-item subscale of the original DES, is generally regarded as a measure of pathological dissociation (Carlson et al., 1993; Waller & Ross, 1997). The Chinese version of the DES-T is reliable and valid and a cutoff score of 27 or 28 is recommended (Fung, Choi, et al., 2018).

The Post-traumatic Stress Disorder (PTSD) Checklist for DSM-5 (PCL-5) is a commonly-used measure of PTSD symptoms (Blevins, Weathers, Davis, Witte, & Domino, 2015). The PCL-5 has been validated in the Chinese context and a cutoff score of 49 is recommended (Fung, Chan, Lee, & Ross, 2019).

The 9-item Patient Health Questionnaire (PHQ-9) is a widely-used measure of depressive symptoms and is strongly correlated with the Beck Depression Inventory-II (Kung et al., 2013). The Chinese version of the PHQ-9 has been validated and the recommended cutoff score is 15 (Yeung et al., 2008).

The Self-report Dissociative Disorders Interview Schedule (SR-DDIS) is a self-administered version of the DDIS; the DDIS is a reliable and valid interview for DDs and it also includes sections for other related issues, such as substance abuse and BPD symptoms (Ross & Ellason, 2005; Ross et al., 1989). The SR-DDIS is reliable and valid, including in the Chinese context (Fung, Choi, et al., 2018; Ross & Browning, 2017). In particular, the BPD section of the SR-DDIS has been validated (Fung, Chan, et al., 2020). However, OSDD cannot be assessed using the SR-DDIS. The substance abuse, DID-associated features, BPD and DDs sections of the SR-DDIS were included in the screening survey.

The Brief Betrayal Trauma Survey (BBTS), which has 12 items, was used because it can assess 12 different types of childhood and adulthood trauma, including both high-betrayal and low-betrayal trauma (Goldberg & Freyd, 2006). The Chinese version of the BBTS has been reported in the literature (Chiu et al., 2010).

The Self-deprecation subscale of the Perceived Psychiatric Stigma Scale (PPSS-SD) was also included in the online survey. The PPSS, which uses a 4-point scale (1 = totally disagree, 4 = totally agree), is a validated Chinese measure of perceived psychiatric stigma (Han & Chen, 2008).

As the recent literature suggests that the psychosocial needs of people with pathological dissociation should receive more attention (Fung, Ross, & Ling, 2019), we initially developed a brief questionnaire, called *the Psychosocial Needs Questionnaire (PNQ)*, to assess participants' psychosocial needs in eight different areas (e.g., financial and housing needs) (PNQ-Needs) and perceived professional support received to address these psychosocial needs (PNQ-Support). Advice was sought from a small group of social workers to modify the questionnaire. The PNQ was completed by a subsample in the Time 2 survey. Both the PNQ-Needs ($\alpha = .759$) and the PNQ-Support ($\alpha = .776$) had acceptable internal consistency in this subsample.

Data analysis

This study was descriptive and exploratory in nature. We report the descriptive data from the study. Analysis was also conducted to examine correlations between variables and differences between subgroups (e.g., participants from different locations, participants with and without a clinical diagnosis of DD, and participants who were and were not receiving psychotherapy for post-traumatic/dissociative symptoms).

Results

Overall sample characteristics

There were N = 72 participants in total (M_{age} = 28.8; SD = 8.10); 88.9% of them were female. No gender differences were found in the scores on trauma and mental health measures. Most participants were from Hong Kong (n = 38) and Taiwan (n = 33), and one participant was from Guangzhou. Except for childhood low-betrayal trauma, no differences were found in the scores on trauma and mental health measures between Hong Kong and Taiwan participants – Taiwan participants reported significantly more types of childhood low-betrayal trauma than Hong Kong participants (M = 1.85; SD = 1.18 vs M = 1.21; SD = 1.26), t = 2.199, p = .031. A subsample of 64 participants completed the Time 2 survey.

Trauma history

Self-reported traumatic experiences were common in this sample. Table 1 reports the frequency of the each BBTS item. Childhood emotional abuse (80.6%) and physical abuse (50.0%) and adulthood emotional abuse (69.4%) were the most common types of complex trauma. When considering "1 or 2 times" or "more than that" as being positive for that item, participants reported an average of 1.49 (SD = 1.26) types of childhood low-betrayal trauma, 2.61 (SD = 1.50) types of childhood high-betrayal trauma, 1.29 (SD = 1.32) types of adulthood low-betrayal trauma, and 1.97 (SD = 1.29) types of adulthood high-betrayal trauma. Only five participants (6.9%) did not report any high-betrayal trauma.

Mental health assessment

This sample ($M_{DES\text{-}T}$ = 56.2; SD = 18.1) (range = 28.8 to 71.3) reported an average of 6.58 (SD = 3.50) DID-associated features and 5.43 (SD = 2.19) BPD symptoms on the SR-DDIS. Table 2 shows the frequency of DID-associated features in this sample. For comparison purposes, we also reported the data of a previously-reported Chinese sample of people with depression (N = 68): people with depression in that sample ($M_{DES\text{-}T}$ = 16.1; SD = 14.1) reported an average of 1.63 (SD = 2.13) DID-associated features and 3.96 (SD = 2.61) BPD symptoms (unpublished data of Fung & Chan, 2019).

On the SR-DDIS, 18 participants (25.0%) met the diagnostic criteria for dissociative amnesia, 8 (11.1%) met the criteria for dissociative fugue, 5 (6.9%) met the criteria for depersonalization/derealization disorder, and 13 (18.1%) met the criteria for DID; a total of 28 participants (38.9%) met the criteria for a DD of some kind.

In addition, 47 participants (65.3%) met the criteria for BPD (i.e., number of symptoms >= 5) and 15 participants (20.8%) reported a history of substance abuse on the SR-DDIS; 59 participants (81.9%) scored above the cutoff for PTSD (i.e., >= 49) on the PCL-5, while 50 participants (69.4%) scored above the cutoff for depression (i.e., >= 15) on the PHQ-9.

Prior clinical diagnoses made by a psychiatrist or a clinical psychologist

Most participants self-reported a lifetime clinical diagnosis of depressive disorder (62.5%) made by a psychiatrist or a clinical psychologist, 50.0% self-reported an anxiety disorder, 48.6% self-

reported a DD of any kind (including 20.8% DID and 4.2% OSDD/DDNOS), 44.4% self-reported PTSD, 36.1% self-reported a psychotic disorder (i.e., schizophrenia, "early psychosis", and/or bipolar disorder), 29.2% self-reported complex PTSD, 22.2% self-reported BPD, and 18.1% self-reported panic disorder. Participants with a clinical diagnosis of DD reported significantly more DID-associated features than those without a clinical DD ($M = 8.09$; $SD = 3.69$ vs $M = 5.16$; $SD = 2.64$), $t = 3.883$, $p < .001$; but the two groups had no significant differences in trauma or PTSD, BPD or depressive symptoms.

Service usages

Participants commonly had an early onset of psychological problems. The average age at the first time of having mental health problems was 15.6 years ($SD = 6.79$). Most participants were seeing psychiatrists (defined as 3 times or more appointments in the past 12 months) (66.7%), but only a minority of participants were seeing psychologists (38.9%), counsellors (29.2%), or social workers (25.0%).

Regarding current treatment usages, most participants (73.6%) reported receiving medication treatments for mental health problems, while 43 participants (59.7%) reported receiving psychotherapy for post-traumatic/dissociative symptoms.

It should be noted that participants who were and were not receiving psychotherapy for post-traumatic/dissociative symptoms did not statistically differ in any trauma and mental health scores, including the DES-T scores ($M = 57.0$; $SD = 18.8$ vs $M = 55.1$; $SD = 17.3$), PCL-5 scores ($M = 60.2$; $SD = 14.2$ vs $M = 62.0$; $SD = 8.78$), PHQ-9 scores ($M = 17.3$; $SD = 8.71$ vs $M = 17.0$; $SD = 4.33$), BPD symptoms ($M = 5.49$; $SD = 2.00$ vs $M = 5.34$; $SD = 2.48$) and DID-associated features ($M = 6.88$; $SD = 3.84$ vs $M = 6.14$; $SD = 2.91$). It appears that some participants had the chance of receiving psychotherapy, while other participants did not have the chance, even though they did not differ in trauma history and clinical symptoms.

Stigma

On the stigma measure, the PPSS-SD score ($M = 14.2$; $SD = 5.26$) was significantly correlated with the PCL-5 score ($r = .265$, $p = .034$), the PNQ-N score ($r = .328$, $p = .008$) and exposure to information about dissociation and DDs from sources other than therapists (e.g., friends,

media, Internet) ($r = -.287$, $p < .05$). This indicated that stigma was positively associated with PTSD symptoms and psychosocial needs; knowledge about dissociation might help reduce stigma. Table 3 reports the frequencies of the PPSS-SD item scores, which show that mental health stigma was not uncommon in this sample. For example, most participants (66.7%) felt that they were worse than others, and almost half of the participants (47.2%) felt ashamed to have mental health problems.

Psychosocial needs

The PNQ was completed by 64 participants. The PNQ-N score (a measure of psychosocial needs) was correlated with the PCL-5 ($r = .334$, $p = .007$), the PHQ-9 ($r = .438$, $p < .001$) and the number of BPD symptoms ($r = .438$, $p < .001$). This finding implied that psychosocial needs were associated with more clinical symptoms.

As shown in Table 4, most participants reported distress or stress resulting from financial problems, schoolwork or occupational problems, interpersonal problems and psychological problems. Housing problems were not uncommon. However, most participants had not received much support from the service system to deal with schoolwork or occupational, financial and housing problems. Psychiatric medication treatments were the most common intervention; many participants (43.8%) did not receive any in-depth psychotherapy.

Discussion

This paper reports the first data regarding trauma histories, mental health symptoms, clinical diagnoses and service usages in a convenience sample of Chinese people with self-reported symptoms of pathological dissociation. We also made the first attempt to assess the level of stigma and psychosocial needs of people with pathological dissociation. Major findings include: (1) consistent with the Western literature, this Chinese sample was characterized by a history of trauma and high levels of trauma-related symptoms and depression; (2) medication treatments were the most common interventions and many participants did not receive psychotherapy; (3) no differences in trauma and clinical symptoms were found between participants who had and who did not have the chance to receive psychotherapy for post-traumatic/dissociative symptoms; and, (4) stigma and unmet psychosocial needs were common.

This study suffers from some limitations. For example, we relied on self-report data; and the PNQ has not been validated. No structured interviews were conducted, and the clinical diagnoses self-reported by the participants may not be reliable, therefore the actual diagnostic profile of each participant cannot be confirmed. In our experience, DDs are rarely diagnosed in clinical settings in the Chinese context (Fung & Lao, 2017; Fung, Lee, Lao, & Lin, 2017); individuals sometimes endorsed "unsure" on some diagnostic items on the SR-DDIS because they were not sure about their own symptoms. Therefore, the prevalence of DDs is likely to be underestimated in this sample no matter whether based on the SR-DDIS results or according to self-reported clinical diagnoses; the figure (38.9%) was provided for reference only. The sample was not representative of all Chinese people with pathological dissociation because data were from an intervention study that provided incentives (a lottery draw) and because most of the participants were female. The use of incentives and the nature of an intervention study may produce bias in this study as participants may over-report symptoms on self-report measures. These limitations undoubtedly limit the generalization of our findings to other clinical populations and highlight the need for further investigation in a more representative Chinese sample. The results of this study, hence, should be interpreted with caution. Nevertheless, we used well-established mental health measures, conducted interviews to ensure the participants' identities, and excluded participants with a relatively low DES-T score. This study indicates that the clinical patterns of people with pathological dissociation as described in the international literature (e.g., frequent trauma, DID-associated features and comorbid symptoms) can be observed in this Chinese sample and that the psychosocial needs of Chinese people who reported dissociative symptoms should not be overlooked.

Although this sample was highly traumatized and dissociative and most participants exhibited severe trauma-related psychopathology, medication treatments were the most common interventions; a considerable number of participants did not receive psychotherapy. No clinical differences were found between participants who had and had not received psychotherapy for post-traumatic/dissociative symptoms. This finding implies that trauma therapy resources may not have been offered according to the clinical needs of the participants. Since our participants were treatment seekers, it is likely that Chinese people with unrecognized pathological dissociation are underserved

in the service systems. Given the considerable psychopathology of this population, regular trauma and dissociation assessment is necessary in clinical settings. More dissociation-informed services should be available for Chinese speakers. Furthermore, although the clinical features of people with self-reported symptoms of pathological dissociation are similar across cultures, dissociation-focused therapy for Chinese-speaking clients may require culturally-sensitive modifications. For example, Chinese people may be less likely to seek help for psychological problems (Chen & Mak, 2008) and more efforts at engagement may be needed; filial piety in Chinese cultures may potentially cause boundary issues within a family; and, emotional maltreatment may be mistakenly believed to be harmless (Fung, Chung, & Ross, 2020). Chinese trauma survivors' idiom of distress and explanatory model of suffering should be understood in order to eliminate the fear of social stigma and to improve access to care and treatment outcome.

We made the first attempt to show that stigma and psychosocial needs were common among people who reported symptoms of pathological dissociation. Early psychoeducation may be helpful to destigmatize pathological dissociation as it is an understandable response to trauma and stress. Our findings highlight the importance of recognizing the psychosocial needs of this population. People with pathological dissociation commonly have many psychosocial needs (e.g., having an abusive family member, needing financial resources to stay away from traumatizing environments), and therefore social workers can play a unique role to support them to address such psychosocial needs (Fung, Ross, & Ling, 2019). The data indicate that, while psychosocial needs were associated with more comorbid symptoms, many participants did not receive enough professional psychosocial support. This highlights the importance of dissociation training for social workers. Further studies are required to examine the psychosocial needs of this population. People with pathological dissociation usually have fluctuating symptoms and relapses and respond poorly to interventions when there are ongoing traumas and stressors. As dissociation is an understandable reaction to adverse psychosocial experiences, such psychosocial difficulties should be addressed before a survivor can have a good progress for recovery. Future studies should also explore the lived experiences of Chinese survivors to further understand their psychosocial needs and examine whether social interventions that target such needs (e.g., housing and financial needs) are effective at reducing clinical symptoms.

Concluding remarks

This paper reports the first data regarding the clinical features of a sample of Chinese people who screened positive for pathological dissociation on a self-report measure. The data support the trauma model of pathological dissociation (Fung & Lao, 2017; Ross et al., 2008). Regular trauma and dissociation assessments for Chinese people with mental health problems are important. More dissociation-focused services should be developed for Chinese-speaking populations. Further studies are necessary.

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