

Association between Dissociative Symptoms and the Severity of Positive and Negative Symptoms in Patients with SchizophreniaRaj Kumar Sahu¹, Dip P Bhadja², Pragna Sorani³, Nidhi S Surani^{4*}¹Assistant Professor, Department of Psychiatry, ESIC PGIMSR and Model Hospital, Basaidarapur, New Delhi, India²Assistant Professor, Department of Psychiatry, GMERS Medical College, Morbi, Gujarat, India³Associate Professor, Department of Psychiatry, GMERS Medical College, Morbi, Gujarat, India⁴Senior Resident, Department of Psychiatry, Shri Ramkrishna Institute of Medical Sciences & Sanaka Hospitals, Durgapur, West Bengal, India

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Abstract**Background:** Five phenomena constitute the primary clinical components of dissociative psychopathology: amnesia, depersonalization, derealization, identity confusion, and identity alteration. There is a high degree of phenomenological overlap and functional interplay between schizophrenic syndromes, posttraumatic conditions and dissociative disorders. The present study aimed to see if there is any association between adult dissociative symptoms and general psychopathology in patients with schizophrenia.**Materials & Methods:** The study had a cross-sectional design with purposive sampling with a sample size of 60 patients with schizophrenia who were assessed by the Dissociative Experiences Scale (DES-II) and Positive and Negative Syndrome Scale (PANSS) for Schizophrenia.**Results:** The Mean DES score was 14.67 ± 9.90. Total 8.3% of the subjects reported high dissociation (Mean DES score ≥ 30). There was a significant positive correlation between Dissociative symptoms (measured by Mean DES score) and Psychopathology (measured by PANSS positive symptoms and Total PANSS score) in patients with schizophrenia.**Conclusion:** The concept of dissociation or dissociative symptomatology is widely associated with psychotic symptoms. The present study emphasizes the importance of assessing dissociative symptoms in patients with schizophrenia to ensure that the most appropriate and effective interventions are provided to this patient group.**Keywords:** Correlation, Dissociative Experiences Scale, Psychopathology, Schizophrenia, Symptoms.This is an Open Access article that uses a funding model which does not charge readers or their institutions for access and distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0>) and the Budapest Open Access Initiative (<http://www.budapestopenaccessinitiative.org/read>), which permit unrestricted use, distribution, and reproduction in any medium, provided original work is properly credited.**Introduction**

The central feature of dissociation is disruption to one or more mental functions. Such disruption may affect not only consciousness, memory, and/or identity, but also thinking, emotions, sensorimotor functioning, and/or behavior. Five phenomena constitute the primary clinical components of dissociative psychopathology: amnesia, depersonalization, derealisation, identity confusion, and identity alteration. They are usually accompanied by secondary symptoms of dissociation which may have positive (e.g., hallucinations, Schneiderian experiences) or negative (e.g., somatosensory deficits) characteristics [1].

Based on the commonness of trauma and its putative aftermath, dissociation, in schizophrenia, Ross and Keyes have introduced a theory of dissociative schizophrenia which has been demonstrated by

subsequent studies as well. These patients have symptoms of Dissociative Identity Disorder (DID) and schizophrenia concurrently [2].

Bleuler's description of the clinical symptoms in schizophrenia includes explicit and detailed phenomenology that matches that of the Diagnostic and Statistical Manual of Mental Disorders Text Revision of the fourth edition's (DSM-IV-TR) dissociative identity disorder. Bleuler repeatedly refers to a splitting of the personality, switching of executive control, amnesia between personality states, conflict between personality states, different ego states with different names and ages, and changes in voice, facial expression, manner and cognition which match the different ages and genders of the personality states. He provides a rich description of somatic symptoms and other comorbidity typical of DID [3].

Dissociation in patients with schizophrenia might signify a poorer outcome of schizophrenia in some patients, who may be treated more effectively if dissociation did not go unnoticed for conceptual reasons. Most of the evidence linking adult dissociative symptoms and general psychopathology in patients with schizophrenia has been derived from studies in Western cultures. The present study aimed to see if there is any association between adult dissociative symptoms and general psychopathology in patients with schizophrenia in the Indian population.

Materials & Methods

Null Hypothesis: There is no relationship between dissociative symptoms and psychopathology of schizophrenia.

Subjects and Design: This cross-sectional, hospital-based study was conducted at a government hospital. Patients were taken up for the study from the outpatient and inpatient department. Total 60 patients with a diagnosis of schizophrenia were included in the study using the purposive sampling method. All patients were diagnosed as a case of Schizophrenia as per the criteria laid by ICD-10 DCR (Diagnostic Criteria for Research). The Scientific and Ethical Committee of the Institute approved the study. Signed informed consent was obtained from the study patients.

Inclusion Criteria

- Diagnosis of schizophrenia according to ICD-10 (DCR).
- Patients aged between 18-50 years.
- Patients giving written informed consent.
- Minimum education of up to 10th class.

Exclusion Criteria

- Mental retardation.
- Significant head injury resulting in loss of consciousness.
- History of major physical and neurological diseases.
- Subjects not willing to give written informed consent.
- Clinical states leading to potential risks in the case of participation (e.g., persisting acute suicidality, severe positive or negative symptoms such that the patient is inattentive/ uncooperative, patients with increased psychomotor activity.)

Data Collection

1. Semi-structured Proforma for Socio-Demographic and Clinical Details- It includes information like age, sex, education, marital status, etc. The clinical data sheet includes information like duration of illness, past history, treatment history, etc.

2. Positive and negative syndrome scale (PANSS) for schizophrenia- PANSS is a 30-item, seven-point (1 to 7) rating instrument for assessing positive, negative and other symptoms in schizophrenia. The component scales are operationalized by provisions of detailed definitions for each symptom at all levels of severity. Of the 30 items included in the PANSS, 7 constitute a Positive Scale, 7 a Negative Scale, and the remaining 16 a General Psychopathology Scale. [4] The PANSS has high inter-rater reliabilities (0.80). The split half reliability of the General Psychopathology subscale is 0.80. The scale has also demonstrated excellent criterion-related validity and construct validity [5].
3. Dissociative Experiences Scale (DES-II): It is used to assess dissociative symptomatology [6]. The scale consists of 28 items and provides both a total score and scores for each of three subscales [7]:

Dissociative Amnesia (DAM): Items 3, 4, 5, 8, 25, 26.

Absorption and Imaginative Involvement (ABI): Items 2, 14, 15, 17, 18, 20.

Depersonalization/Derealization (DP): Items 7, 11, 12, 13, 27, 28.

In the DES-II, the items are answered on a percentage scale that measures the frequency with which each of the symptoms described in the items on the scale occurs in daily life. The respondent scores 0% if what is described has never happened to him or her, and 100% if it occurs very frequently. The sum of the 28 items was divided by 28 to form a Mean DES score for each individual. There is no cut off point indicating pathology because the scale is oriented towards the quantitative measurement of dissociative symptoms. However, researchers can calculate the percentage of subjects who score 30 or higher on the DES. A score of 30 provides an empirically derived breakpoint for dividing a sample into high and low dissociators [6]. The DES-T is a subset of 8 items [items 3, 5, 7, 8, 12, 13, 22, and 27] on the DES that are inherently pathological. Taxometric analysis of these items yields a high probability that an individual is in one of two discrete categories; normal, or suffering from pathological dissociation. Individuals with pathological dissociation are said to be in the dissociative taxon [8]. Concerning psychometric properties, the scale has high test-retest reliability (ranging from 0.78 to 0.96) and high internal consistency (Cronbach's alpha = 0.95). It also has good construct validity and high sensitivity and specificity to appropriately identify individuals with dissociative symptomatology and exclude those with no dissociative symptoms-74 and 80 %, respectively [7].

Statistical Analysis: The statistical analysis of data was performed using the "Statistical Package for Social Science software version 24.0 for Windows (SPSS, Chicago, Illinois, USA). Differences between groups were considered significant if p-values were smaller than 0.05. Descriptive statistics were used to define sample characteristics. Pearson's correlation test was used to explore the association between dissociative symptoms and psychopathology of patients with schizophrenia.

Results

The present cross-sectional study included 60 patients diagnosed with schizophrenia as per ICD-10 DCR criteria. Table 1 highlights the socio-demographic characteristics of the participants. All subjects were aged between 18 and 50 years and had a minimum educational qualification of 10th grade. Among them, 33 patients (55%) were aged 18–34 years, while 27 (45%) were aged 35–50 years. The study population had an equal gender distribution, with 30 males (50%) and 30 females (50%). Regarding marital status, 27 (45%) participants were single, 30 (50%) were married, and 3 (5%) were either separated or divorced. Most subjects were Hindu (58, 96.7%), with the remaining 2 (3.3%) belonging to other religions such as Muslim, Christian, or Sikh. Educationally, 21 (35%) participants had completed 10th grade, 20 (33.3%) had studied up to 12th grade, and 19 (31.7%) were graduates or held higher qualifications. Employment status revealed that 19 (31.7%) subjects were employed, while 41 (68.3%) were unemployed. Socioeconomic status (SES) showed that 30 (50%) belonged to the lower SES, 26 (43.3%) to the middle SES, and 4 (6.7%) to the upper SES. Family structure analysis indicated that 24 (40%) participants lived in nuclear families, whereas 36 (60%) lived in joint families. Geographically, 18 (30%) subjects resided in rural areas, while 42 (70%) were from urban settings. A family history of mental illness was present in 27 (45%) participants, while 33 (55%) had no such history.

Table 2 presents the descriptive analysis of the Dissociative Experiences Scale (DES-II) scores among 60 patients with schizophrenia. All participants completed this self-reported instrument, and scores were calculated for its three subscales. The Absorption and Imaginative Involvement subscale had a mean score of 12 ± 8.79 , while the Amnesia subscale scored a mean of 8.70 ± 7.47 . The Depersonalization/Derealization subscale recorded a mean score of 5.49 ± 6.60 . The Taxon items of the DES-II showed a mean score of 11.10 ± 8.68 . The overall

mean DES score, representing the average of all 28 items, was 14.67 ± 9.90 .

Table 3 categorizes the study population based on their mean DES scores into two groups: "High Dissociators," with a mean DES score of 30 or higher, and "Low Dissociators," with a mean DES score below 30. Among the 60 participants, 55 (91.7%) were identified as "Low Dissociators," while 5 (8.3%) were classified as "High Dissociators."

Table 4 details the application of the Positive and Negative Syndrome Scale (PANSS) to 60 patients with schizophrenia, summarizing the mean and standard deviation for each subscale. The PANSS Positive Symptoms subscale had a mean score of 13.63 ± 5.39 , the PANSS Negative Symptoms subscale had a mean of 15.31 ± 6.62 , and the General Psychopathology subscale recorded a mean of 25.41 ± 6.50 . The Total PANSS score, obtained by summing the three subscale scores, showed a mean of 54.20 ± 13.39 .

Table 5 illustrates the correlations between the Mean Dissociative Experiences Scale (DES) scores and PANSS subscales. A significant positive correlation was found between the Mean DES score and both PANSS Positive Symptoms ($P < 0.05$) and Total PANSS scores ($P < 0.05$). However, no significant correlation was observed between the Mean DES score and PANSS Negative Symptoms or General Psychopathology.

Further analysis revealed significant positive correlations between:

- The **"Absorption and Imaginative Involvement"** subscale of DES and PANSS Positive Symptoms ($r = 0.332$, $P < 0.05$), PANSS Negative Symptoms ($r = 0.272$, $P < 0.05$), General Psychopathology ($r = 0.258$, $P < 0.05$), and Total PANSS scores ($r = 0.397$, $P < 0.05$).
- The **"Amnesia"** subscale of DES and PANSS Positive Symptoms ($r = 0.32$, $P < 0.05$).
- The **"Depersonalization/Derealization"** subscale of DES and PANSS Positive Symptoms ($r = 0.361$, $P < 0.05$).
- **Taxon items** on DES and PANSS Positive Symptoms ($r = 0.422$, $P < 0.05$) and Total PANSS scores ($r = 0.257$, $P < 0.05$).

These findings suggest specific dissociative subscales are positively associated with particular dimensions of symptomatology in schizophrenia.

Table 1: Socio-demographic profile of study sample (patients with schizophrenia)

Variables	N(%)
Age (in years)	
18 -34	33(55)
35-50	27(45)
Gender	
Male	30(50)
Female	30(50)
Marital Status	
Single	27(45)
Married	30(50)
Others	3(5)
Religion	
Hindu	58(96.7)
Others	2(3.3)
Education	
High school	21(35)
Intermediate	20(33.3)
Graduate & above	19(31.7)
Occupation	
Employed	19(31.7)
Unemployed	41(68.3)
Socio-economic-status	
Lower	30(50)
Middle	26(43.3)
Upper	04(6.7)
Family structure	
Nuclear	24(40)
Joint	36(60)
Residence	
Rural	18(30)
Urban	42(70)
Family History	
Absent	33(55)
Present	27(45)

Table 2: Descriptive statistics of DES-II in 60 patients with schizophrenia –

DES Variables	Mean \pm SD
Absorption and imaginative involvement	12.0 \pm 8.79
Amnesia	8.70 \pm 7.47
Depersonalization/ derealization	5.49 \pm 6.60
Taxon	11.10 \pm 8.68
Mean DES score	14.67 \pm 9.90

Note: DES- Dissociative Experiences Scale

Table 3: Descriptive statistics involving bifurcation of Mean DES scores

Category	N(%)
Low Dissociators	55(91.7)
High Dissociators	05(8.3)

Note: DES- Dissociative Experiences Scale

Table 4: Descriptive statistics of PANSS in 60 patients with schizophrenia-

PANSS	Mean \pm SD
Positive symptoms	13.63 \pm 5.39
Negative symptoms	15.31 \pm 6.62
General psychopathology	25.41 \pm 6.50
PANSS Total score	54.20 \pm 13.39

Note: PANSS- Positive and Negative Syndrome Scale for Schizophrenia

Table 5: Pearson's correlation between DES and PANSS in 60 patients with schizophrenia

PANSS items DES subscales	Positive symptoms	Negative symptoms	General Psycho- pathology	Total PANSS
Absorption and imaginative involvement	0.332*	0.272*	0.258*	0.397*
Amnesia	0.320*	0.041	0.046	0.171
Depersonalization/ Derealization	0.361*	0.006	0.90	0.194
Taxon	0.422*	0.16	0.157	0.257*
Mean DES score	0.481*	0.176	0.219	0.389*

* $p < 0.05$

Note: DES- Dissociative Experiences Scale, PANSS- Positive and Negative Syndrome Scale for Schizophrenia

Discussion

The high rate of unemployment observed in this study may be attributed to the inherent nature of schizophrenia, characterized by social isolation, severe psychopathology, poor medication compliance, and social stigma. A minimum education level of 10th grade was set as an inclusion criterion to ensure comprehension of the DES questionnaire, which contains complex statements requiring a basic level of literacy. Among the 60 participants, the gender distribution was equal, with 30 males and 30 females.

Table 2 highlights the Mean DES score, which was 14.67 ± 9.90 in this study. This finding aligns with previous research, where the Mean DES score has been reported to range from 11.9 to 21 points, supporting the consistency of dissociative symptoms across similar populations [9-11].

Some authors have also documented the existence of a dissociative subgroup among patients with schizophrenia [12]. As depicted in Table 3, in the present study, 8.3% of subjects were found to be "High dissociators" i.e. a Mean DES score of greater than or equal to 30. This result was consistent with the findings of another study in which the DES score was found to be above 30 in 13% of the patients with schizophrenia [13].

As depicted in Table 5, a significant positive correlation was found between the Mean DES score and PANSS-positive symptoms ($r=0.481$, $P<0.05$) and total PANSS score ($r=0.389$, $P<0.05$) in patients of schizophrenia in our study. This finding is consistent with other studies [2,14-17]. No significant association could be found between the Mean DES score and negative symptoms of PANSS. This result is consistent with the findings of some authors [13]. Some studies have found that there was a more proximal relationship between schizophrenia and dissociation. It was found that dissociative symptoms are associated with an increased severity of positive and negative symptoms in patients with schizophrenia. These findings are consistent with the hypothesis that a dissociative pathway to psychosis could induce core symptoms of schizophrenia in a subgroup of patients diagnosed with schizophrenia. The study revealed that those with high dissociation were also

confronted with a more severe episode of schizophrenia than those with trauma [12,18].

Research suggests a high degree of phenomenological overlap and functional interplay between schizophrenic syndromes, posttraumatic conditions and dissociative disorders [19,20]. Not only does this pose the question of differential diagnosis and comorbidity, but it may also be accounted for by shared risk factors, fuzzy boundaries between the overlapping diagnoses or a mutual effect on the respective vulnerability. Accordingly, some authors propose a duality (interaction) model to explain the complex co-existence of two qualitatively distinct but interactive, concurrent or subsequent psychopathologies as a possibility [21].

A significant positive correlation was also found between the "Absorption and imaginative involvement" subscale of DES and PANSS (Positive symptoms, Negative symptoms, General psychopathology and PANSS Total score). A significant positive correlation was found between the "Amnesia" subscale of DES and PANSS (Positive symptoms). A significant positive correlation was found between the "Depersonalization/ Derealization" subscale of DES and PANSS (Positive symptoms). These findings are consistent with other studies where it was found that the subscales of DES and Positive symptoms of PANSS have a consistent relationship [11, 14, 22-24]. A significant positive correlation was also found between Taxon items on DES and PANSS (Positive symptoms and PANSS Total score). A possible explanation for the relationship between psychotic and dissociative symptoms is an interaction between both types of psychopathology. It has been suggested that severe dissociation or symptoms of PTSD may produce psychotic symptoms or could be a mediating factor in their development [25, 26]. Some authors have emphasized the special role of dissociative detachment in this context. They suggested that dissociative detachment "undermines the individual's grounding in the outer world, thereby hampering reality-testing and rendering the individual with posttraumatic symptoms vulnerable to the nightmarish inner world" [27]. Other authors suggest an inverse relationship. They proposed that dissociation might arise as a defense against the "disorganizing pressure of abnormal affect" in patients with psychotic mood disorders or

that psychotic symptoms might lower the threshold for the expression of dissociation in patients predisposed to this phenomenon because of early trauma [28]. They referred to cases where even severe dissociative symptoms, such as alternate personalities and amnesic episodes, disappeared when the psychotic disorder was successfully treated. Finally, both psychotic and dissociative manifestations could be an independent result of reactivated traumatic memories in some patients.

Study limitations

The readers are cautioned against over-interpreting study results because this study has one major limitation:

- The sampling strategy involved the recruitment of stable patients with schizophrenia and many had only moderately severe psychotic syndromes. The inclusion of more severely ill patients might have led to different findings.

Conclusion

The study of dissociation in a population having schizophrenia is relevant because of the high rate of traumatic experiences that occur in the severely mentally ill. The concept of dissociation or dissociative symptomatology is widely associated with psychotic symptoms. A natural, protective response to overwhelming traumatic experiences, dissociation can become an automatic stress response. This can impair functioning and increase susceptibility to serious psychopathology. The present study emphasizes the importance of assessing dissociative symptoms in patients with schizophrenia to ensure that the most appropriate and effective interventions are provided to this patient group.

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