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# Psychiatric visual expression interview in dissociative disorders

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## Abstract

Psychiatric assessment of dissociative disorders is often complicated by the very core phenomena of these disorders: disconnections of cognitive, emotional and perceptual processes of the client lead to scattered information derived from psychiatric interview. The diagnostically relevant disconnections may become evident by direct observations rather than by anamnesis during a time-limited assessment. Complementary visual expression techniques are helpful in enhancing communication and the self-expression of the client, and offer a broader spectrum of observation for the clinician than a standard verbal interview. Besides they may enhance symptom awareness, and thus relieve patients' anxiety and enhance their engagement in treatment.

## Introduction

Dissociative symptoms and dissociative disorders have ambiguous definitions. Dissociation as a word means disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, and that results in discontinuities in conscious awareness. Disconnection may involve usually integrated functions of consciousness, memory, identity or perception. Persons suffering from dissociation may experience thoughts, emotions, sensory feelings or actions that seem to come from nowhere or outside, and are thus confusing. Depersonalization is the sense of being detached from one's body and includes symptoms like not recognizing one's mirror image, being unconnected to sensory or visceral sensations and out-of-body experiences. Derealization is the sense of the world not being real: the world looks falsified, foggy or is like watching a movie. Amnesia manifests as inability to recall important personal information, varying from a small scale of missing parts or a whole conversation, to missing years of one's life memories.

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, APA 2013) (1) describes pathological dissociation as "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour". This captures dissociative symptoms as both mental and physical phenomena. Dissociative disorder diagnoses do not require a preceding specific stressor or trauma, although they are recognized to closely associate with traumatic experiences. DSM-5 includes Depersonalization Disorder (DPD) that includes derealization, Dissociative Amnesia (DA) with Dissociative Fugue (DF) as a subtype, controversial diagnosis of Dissociative Identity Disorder (DID) includes both identity fragmentation and possession, thought to apply better in different cultural situations, and finally Dissociative Disorder Not Otherwise Specified (DDNOS) (2). Conversion disorder (functional neurological symptom disorder) remains with the somatic symptom disorders in the DSM-5, and post-traumatic stress disorder (PTSD) has a dissociative subtype with depersonalization and/or derealization syndromes within the class of trauma and stress-related disorders. Thus, the syndromes with dissociative symptoms are scattered into different classes.

ICD-10 (3) combines dissociative and conversion disorders into one class (F44). It includes diagnoses of DA, DF, Dissociative stupor, Trance and possession disorders, Dissociative motor disorders, Dissociative convulsions, Dissociative anaesthesia and sensory loss, Mixed dissociative (conversion) disorders, Other dissociative (conversion) disorders (includes Ganser's syndrome, Multiple personality disorder, Transient dissociative (conversion) disorders occurring in childhood and adolescence, Other specified dissociative (conversion) disorders) and finally Dissociative and conversion disorder, unspecified. Essentially the proposed ICD-11 dissociative disorders include these same diagnoses. It has been argued that there should be one trauma- and stress-related disorders category that includes diagnoses from simple PTSD to the most complex DID, as all these syndromes share a dissociative component of variable severity (4). Prevalence estimates of dissociative disorders are highly variable across different studies. In the acute aftermath of traumatic experience, dissociative symptoms are highly prevalent (around 60% to 70% experience them) but usually fade away. A prevalence rate of 0.5% to 1.0% of DID in psychiatric settings has been suggested based on previous studies (5).

Yet, the prevalence of dissociative disorders seemed to be surprisingly high, 29% in an urban psychiatric outpatient sample with a high prevalence of childhood traumatization when diagnosed with SCID-D (6, 7). Dissociative Amnesia and Dissociative Disorder Not Otherwise Specified were the most prevalent diagnoses among the patients with dissociative disorders. The comprehensive sample of over 25,000 respondents in the World Mental Health Surveys was assessed for PTSD and for dissociative symptoms of depersonalization and derealization (8). One year prevalence of PTSD was 1.9% of which 14.4% were dissociative subtype. Dissociative symptoms were found in 2.8% of the remaining sample.

Dissociative disorders may have been previously underdiagnosed (6). The typical screening instrument Dissociative Experiences Scale (DES) (9), despite its further validation (10), seems to miss a substantial number of patients with dissociative disorder (11). Various cut-off scores of 15, 20, 25 and 30 have been used with the DES Scale (6).

The Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (7) has been developed for a more thorough structured assessment of dissociative disorders (6). Depersonalization, derealization, amnesia, identity confusion and identity alteration are the main areas assessed in the SCID-D (7). A dissociative disorder is possible when there are enduring symptoms in any of the five areas.

## **Visual expression assessment methods**

Visual products of patients are used in clinical assessment in many ways, ranging from extremely structured tests, such as neurological copying tasks, to the more expressive and reflective assessments where the creative expression of the patient is encouraged. In psychiatry, there are two main traditions, i.e. structured psychological tests and art therapy assessments that have adopted different approaches from psychological and psychotherapeutic frameworks.

The use of visual expression has long traditions in psychological assessment in the form of structured drawing tasks such as House-Tree-Person technique, Goodenough-Harris drawing procedure (12), Machover's Draw-a-person test (13), Silver Drawing Test of Cognition and Emotion (14) and drawing tasks depicting family and other interactions (15).

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Furthermore, psychologists have attempted to incorporate art therapy techniques to augment interaction with non-compliant or non-verbal clients. Drawings can quickly reveal additional and important information on current developmental, intellectual and emotional functioning. They can also discover presenting problems that may not have been assessed through conventional methods of psychological testing (16).

Historically, asking the client to draw a person has been assumed to raise expressions of the client's individual characteristics and experiences (17). An old and well-known projective drawing technique, Machover's Draw-a-person test, is based on the assumption that the drawn figure represents the subject whereas the paper represents the subject's environment (13). The figure drawings bring value as meaningful descriptive content, but their predictability and precise interpretations are questionable (18). Interpretation of the figure drawings without adequate competencies has been cautioned (19).

The lack of valid evidence reduces the value of projective drawing tests. Interpretation of singular signs, in particular, is unreliable (20). Instead, artistic expression can be explored as a sample of cognitive and behavioural actions of the client. First, it is possible to make observations of the client's behaviour while performing the visual task. Second, we can examine the cognitive processes of the client when discussing the task and the visual product (21). Visual expression, like other human functions, is affected by psychopathology and can thus reflect the mental state of the patient, including mood, energy level and concentration, for example (20).

Specific applications of drawing tests have been developed for clinical needs (22, 23). With focused clinical questions it is possible to obtain more precise information when interpreted in the whole clinical context. The most useful and reliable way of using a client's art expression in assessment is to look at the general form of expression instead of details in content and specific signs, and to integrate behavioural observations during the task and the client's verbal reflections on the visual product during the assessment (20).

Using drawings to open pathways of self-expression makes revealing painful thoughts and feelings less threatening and provides some clinically relevant focus for discussion with the client. Because drawings add flexibility and creativity to the encounter with the client, they enhance understanding and promote communication, as well as build cohesion and trust. By asking clients to illustrate their problems,

feelings and situations, they can begin to enlarge their framework for communication and supply alternative symbolic meaning to their experiences. Providing clients alternative ways to communicate should be an essential method in every clinician's toolbox. Drawings have been accepted as a valuable clinical technique for all mental health professionals to incorporate during assessment and therapy. In clinical work, drawings can be used in a variety of ways to expedite assessment and the diagnostic process (16).

## **Art therapy approach to psychiatric assessment**

Art therapies, unlike psychological assessment, focus on the treatment and recovery of the patient. Art therapy assessment is not as exact and standardized as structured psychological testing. In art therapy assessment the findings can be more unexpected and ambiguous. Furthermore, it is more dependent on the situational interaction, reflective capabilities of the patient and interpretation skills of the interviewer. All types of clinical assessment can be performed in a therapeutic manner, but an art therapy assessment naturally includes therapeutic elements.

The benefits of art therapy, including enhanced communication with different kinds of clients, have been observed since the early forties (24) and utilized in modern recovery-oriented and client-oriented mental health practices (25). The art therapy approach extends the applicability of psychotherapeutic intervention and psychiatric assessment to a broad spectrum of clients: from children to senior citizens, from somatic to psychiatric patients, and from non-verbal to highly verbal or verbally complex clients. Via creative expression in art therapy assessment and treatment the client's active role as a subject becomes emphasized. Some patients report it extremely empowering to become visible to themselves and in the clinical assessment. An art therapy interview provides the clinician a richness of information within a safe environment, when properly used.

The high informative value is based on several aspects. First, an art therapy interview helps to visualize images and to create connections between functions of mind, different states of awareness and fields of experiences. Therefore, the client's self-perception, experiences of personal relationships, defences, affect management, insight, creativity and other psychological aspects may become visible (26). Second, it facilitates communication and trust, creating a safe atmosphere for self-expression and stimulating associations. Third, it creates a new dimension of interaction to be

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observed in the clinical situation. In addition to exploring how the client relates to the interviewer, there is a chance to explore how the client relates to his or her creation, the art product. The client's perceptions of and feelings towards the art product is analysed as the aesthetic transference in art psychotherapy (27). Fourth, the whole procedure of producing art reflects the current motor, cognitive, emotional and social processes of the client.

Art therapy-based assessment and generic psychological drawing tests are very different as procedures and their purpose. An art therapist gives instructions depending on the clinical situation, and they vary from very structured tasks with precise themes to free expression with no given theme. According to the clinical situation, there is a selection of art materials for the client to choose from, and with the client's reaction to them as well as choices made, the whole procedure of visual expression is observed. The client's strengths and resources are the focus of interest as well as their problems. Instead of focusing on a precise diagnostic question, the art-based assessment by art therapist aims rather at planning treatment and rehabilitation, assessment of developmental level, severity of symptoms or some clinical concerns (20).

In an art therapy setting, no direct test result feedback is given, but instead, the client is guided to interpret for him or herself the visual imagery by eliciting questions and new views (28). The client is observed and encouraged in the process of forming a relationship to his or her artwork. The phases defined by art therapists are identification, familiarization, acknowledgement, assimilation and disposal, which refer to what the client does in the end with the art product, including all the possibilities from destruction to saving and leaving (29).

Though knowledge on universal and culture-specific symbols and visual arts language in general are useful skills for an art therapist, it is more important to be sensitive to the client's present associations and individual specific visual images: to understand the meaning of visual form, mind function and developmental psychology in order to make a clinical synthesis (26).

The two different traditions of art therapy assessment and structured psychological test are combined in the Diagnostic Drawing Series (DDS). DDS (30) is the first structured visual expression assessment method that has the main focus on structure and form instead of content and detail. DDS by itself does not give a diagnosis, but when used by an educated art therapist it gives concrete and practical information for the diagnostic process. Therefore, it is a complementary method used in a clinical context (30).

There are several other art-based structured assessment methods developed by art therapists for assessment of personality, coping, confidence, problem solving, reality testing, regression and developmental phase. A sensitive art therapy interview with both open and focused tasks, adapted to the clinical situation, may however be most useful and sufficient for assessment (26).

## **The rationale for integrating visual expression interview in assessment of psychiatric outpatients**

The Helsinki University Central Hospital (HUCH) psychiatric outpatient unit for assessment of work ability launched the project "*Developing quality in psychiatric assessment of work ability*" in 2011 to ameliorate the client-orientation, objectivity and effectiveness of clinical assessments. According to referral criteria, the unit specialized in demanding assessments, with ambiguous or controversial data about work performance, psychosocial function or psychiatric diagnosis, and the interrelations between those three concepts.

The project was funded by HUCH and it was awarded by the Finnish Medical Association in 2014. One of the aims was to find new client-oriented and objective assessment methods for the assessment of work ability and rehabilitation planning. Other aims were to shorten the time of assessment with the optimal cooperation of the psychiatric team, to establish cooperation with the networks and to obtain the maximal objective data of functioning. An evaluation of the assessment process was performed in the unit, and an evaluation of the quality of assessments was also performed by client feedback, and feedback collected from other units that referred patients to the assessment of work ability.

Quality of assessment was increased by a work-based and resource-oriented approach (31), and systematic workplace/supportive network/family interviews, whenever the patients allowed it. New assessment methods were looked for and tested to obtain complementary data and to cover the gaps in clinical information and communication with the patients. Some of the new assessment methods were found to be impractical or unsuitable during the project. The client feedback, workteam feedback, new practices and modifications in the assessment procedure have been described in detail in a project report (32) and the patient follow-up outcomes have been published by Heikinheimo and Tuisku (33).

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Complementary objective assessment methods were applied in cases where the routine clinical assessment seemed insufficient. The routine examination included an interview about daily life, functioning and important life events by a nurse, family interview, when possible, symptom assessment and diagnostic interviews SCID 1-2 (34) by a psychiatrist and somatic assessment with laboratory screens. Besides, an assessment of career and social functioning was performed by a social worker and psychological examinations were performed by a clinical psychologist or neuropsychologist when needed. The routine psychiatric examination was enriched with new assessment methods, especially in cases of complex differential diagnostics and controversial perceptions of function.

The complementary objective methods comprised observations of functioning during a practical task guided by an occupational therapist and a semi-structured visual expression interview, Relationship to work, earlier described by Huttula (35), also guided by an occupational therapist. The work-related interview was offered to patients with a complex relationship to work or an unclear functional capacity with possible work-related background factors. In this context, the patient's relationship to work could be visualized and more deeply discussed in terms of values, obstacles, adverse experiences and functional limitations. The strengths and resources also became visible by the visual expression interview (36, 31).

While having used Relationship to work interview since 2010 in assessment of work ability, the potential of visual expression to enhance communication, understanding and visibility of several psychological aspects became evident. The psychiatric team remarked on its value as a complementary assessment method in differential diagnostics, symptom quality and severity evaluation, and in finding out the meaning of symptoms for the patient. With the encouraging preliminary clinical experiences (36), another type of visual expression interview was developed for psychiatric symptom assessment and differential diagnostic purposes, as well as for rehabilitation planning, to be tested during the developmental project. This psychiatric visual expression interview was called *Relationship to self* because the focus is self-perception. The semi-structured interview was tested by a psychiatrist with an art therapist education with the clinical team.

The Relationship to self interview was offered to patients with functional and unclear symptoms, or who had problems with body image or challenges in verbal self-expression due to neuropsychiatric or other special features. We found it particularly useful in assessment of neuropsychiatric patients and patients with dissociative or somatoform



functional symptoms. According to preliminary observations, the visual expression interview seemed to give clinically relevant information about dissociative and somatoform symptoms that are sometimes difficult to approach by routine verbal interviewing techniques (36, 32).

The meaningfulness of visual expression in assessment of clients with functional symptoms was actually not a new observation, but based on earlier data. An art psychotherapy setting has proved to offer an environment for exploration of functional reactions and their motives (26), and the visual expression method has been described to equip the client with a non-verbal, image-based language for identifying and communicating pain and other negative body states (37). The personal meaning of functional symptoms, body image and identity can be explored by visual expression interview.

With art therapy training, the interview will offer more tools to stimulate the client's creative expression and reflections, while also regarding the safety aspects. Either art therapy or other psychotherapeutic training, in addition to clinical experience of traumatic disorders, of the interviewer is needed for performing the visual expression interview with severely traumatized patients.

## Materials and methods

The study setting is clinical, naturalistic and qualitative with limited follow-up data. Profound clinical examination of work ability was performed with 139 consecutive patients, who were referred to Helsinki University Central Hospital outpatient unit for assessment of work ability, in the years of 2011-2012 as part of the "*Developing quality in psychiatric assessment of work ability*" project. The patients of this study sample were assessed between the 23rd March 2011 and 23rd December 2012. The study sample consisted of 132 patients who gave their informed consent. Brief consultative assessments, or assessments focused on clinical questions other than work ability, were not included in this study. The study was approved by Ethical Committee of Helsinki and Uusimaa Hospital district.

## Study sample

Mean age of the patients was 45.0 (range of 24 to 61) years. There were 83 females (63%) and 49 males (37%). Among main referral ICD-10 diagnoses, mood disorders (F30-F39) were the most predominant 65%, followed by anxiety disorders (neurotic, stress-related and somatoform F40-F49) 15%, and psychosis spectrum (schizophrenia, schizotypal and delusional disorders F20-F29) 6%. The distribution of the end diagnoses was quite similar (see Table 1).

The sub-sample of patients that were guided to complementary visual expression interview (see Table 2) consisted of 24 females (73%) and 9 males (27%). Their mean age was 43.3 years.

**Table 1.** Referral and end diagnosis categories among 132 examined patients.

Diagnostic class (ICD-10)	Main diagnosis at referral Number of patients (%)	Main end diagnosis Number of patients (%)
F00-F09 Organic mental disorders	2 (<2%)	1 (<1%)
F10-F19 Mental and behavioural disorders due to psychoactive substance use	0 (0%)	1 (<1%)
F20-F29 Schizophrenia, schizotypal and delusional disorders	8 (6%)	14 (11%)
F30-F39 Mood disorders	86 (65%)	80 (61%)
F40-F49 Neurotic, stress-related and somatoform disorders	21 (16%)	23 (17%)
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	1 (<1%)	1 (<1%)
F60-F69 Disorders of adult personality and behavior	7 (5%)	5 (4%)
F80-F89 Disorders of psychological development	2 (<2%)	2 (<2%)
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1 (<1%)	0 (0%)
Z00-Z99 Factors influencing health status and contact with health services	4 (3%)	5 (4%)

## **Semi-structured visual expression interview**

The theme given in the semi-structured visual expression interview was self-image, and instruction given to the patient was: depict yourself, the way you feel yourself. Extra formulations and modifications to the theme of an imaginary self-portrait were made according to patient history and clinical question. There were, for example, timed series to illustrate a change in the patient's experience of him or herself, patient's self-perception versus the image of others' perceptions of the patient, different states of mind, experiences of identity, different perceptions of surrounding reality, relationship to disturbing symptoms or their triggers, body experiences in functional and dysfunctional states, etc.

Simple art materials were available, including oil crayons, soft pastels, watercolours, poster colours, markers and pencils. Patients' behaviour, visual task performance, interaction and reactions to situation were observed during the process of picture making. Some patients needed encouragement to start, but none of them refused the task and none of them interrupted the interview.

A time window of about 20 minutes was given for making each picture and 20 minutes per picture for exploring it with the patient. With the maximum of three pictures, the interview could last up to two hours including all the discussion.

Exploring the art work with the client started first with silence, and by hanging the picture on the wall, or fixing it somewhere to become dry, so it could be seen by both the client and the interviewer from the same direction. After possible spontaneous comments and discussion initiated by the client, or in the absence of them, the interviewer proceeded with a set of basic questions (38): 1. When you look at the picture, what do you see? (aesthetic surface) 2. What did you want to express? Did you reach the image that you intended? (giving the form) 3. How did you feel when making this picture? What kind of an experience it was? (the experience of visual expression and of performing the task) 4. What does this picture tell? What ideas or new views come to your mind? (giving the meaning).

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## Results

Among referral diagnoses, there were quite few diagnoses of functional disorder: only one dissociative disorder diagnosis, whereas there were 7 somatoform disorder diagnoses. At the end, after profound clinical examination, the only dissociative referral diagnosis was confirmed, whereas 4 of the 7 somatoform diagnoses were unconfirmed and replaced by other diagnoses, such as PTSD, delusional disorder, dissociative disorder and Z-code (indicating no psychiatric diagnosis). Among the final diagnoses there were 12 dissociative diagnoses (F44) and 8 somatoform (F45) diagnoses. Thus most of the dissociative diagnoses were new (92%). Mood disorders (F31-F33) were the most common referral diagnoses for patients that were later diagnosed with dissociative disorder, either presenting comorbid with the mood disorder, or without (Table 3).

The psychiatric visual expression interview "*Relationship to self*" was performed as a complementary diagnostic assessment in addition to routine clinical examination for 33 of the patients (25%). The main rationale, in 20 cases (15%), for guiding the patients to psychiatric visual expression interview, was disturbing symptomatology of unknown aetiology that seemed to be functional, but called for further clarification. The second reason, in 7 cases (5%), was suspected psychosis with the absence of openly psychotic symptoms or with scarce communication. The third reason was, in 4 cases (3%), persistence of psychiatric symptoms despite treatment, due to unknown causes. The fourth reason, in 2 cases (1.5%), was neuropsychiatric communication challenges (Table 2).

Among the 20 patients with functional symptoms, dissociative disorder was excluded in 11 of the patients and found, or confirmed, in 9 of the patients with the contribution of the Relationship to self interview (Table 2). The visual expression interview seemed most useful in exploring and finding clinically relevant dissociative symptoms and experiences that were difficult to identify and classify by routine diagnostic verbal interview. The visual expression interview contributed to most of the new functional diagnoses, and in particular, to the dissociative diagnoses.

<b>Table 2.</b> Patients in psychiatric visual expression interview grouped by clinical problems. Rationale for "Relationship to self" interview for patients, the focus of questions and type of new information that was obtained from the interview and its contribution to diagnosis.			
Rationale for visual expression interview <b>Relationship to self</b>	Number of patients (% of all)	Focus of questions. Information obtained	End diagnoses. Diagnostic conclusions and clinical findings based on accumulated data, contributed by <b>Relationship to self</b> interviews are marked in bold font
Disturbing functional symptoms	20 (15%)	Experience of body/mind functions, body outlines and changes. Quality of bodily sensations and meanings attributed to them. Identity alterations. Disconnections in perceptions and awareness	<b>8 new dissociative diagnoses, severity of depression and suicidal ideation</b> 1 previous dissociative diagnosis confirmed, and <b>accepted and understood by the patient</b> 4 somatoform diagnoses, <b>maladaptive health behaviour and interpretations</b> <b>2 PTSDs</b> <b>1 psychotic spectrum personality disorder</b> <b>1 hypomania</b> 1 bipolar depression 1 unipolar depression 1 no psychiatric diagnosis
Suspected psychosis	7 (5%)	Reality testing, cohesion of expression, quality of psychotic images. Explanation given to them, symptom awareness	<b>3 new psychosis spectrum diagnoses</b> 1 former psychotic diagnosis confirmed, and <b>more severe clinical picture was revealed</b> 1 psychotic spectrum personality disorder 1 non-psychotic mood disorder, less severe and <b>more integrated than expected</b> 1 no psychiatric diagnosis, only work-related crisis. <b>Better role insight, resiliency and wording of emotional reactions than expected</b>
Persistence of mood symptoms	4 (3%)	Problems with confidence, self-image, maladaptive roles and self-attribution	<b>1 primary anxiety disorder and problem with identity</b> <b>1 comorbidity, dysfunctional body image</b> 1 comorbid personality and addiction disorder 1 neurological comorbidity
Neuropsychiatric communication challenges	2 (1.5%)	Self-perception, the patient's own view, stereotypes and cognitive distortions, compensating mechanisms	2 autism spectrum diagnoses. Parallel obsessive and <b>transient psychotic symptoms</b>

The somatoform diagnoses were not directly made by visual expression interview, but the diagnoses became more acceptable for the patients by the increased awareness of their symptom mechanism. After visualizing their bodily experiences and meanings attributed to them, they were more prepared to look at them objectively, gain insight, discuss and utilize psychoeducation. By making pictures of themselves, some patients may find new, more flexible ways to explore and approach their body/mind integrity, instead of a rigid dichotomy between stigmatized psychopathology and verified somatic illness.

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The patients diagnosed with dissociative disorders (N=12) are presented in Table 3. Eight of 11 dissociative diagnoses were partially based on perceptions and discussions from the visual expression interview. Psychological examination was performed for all of the patients diagnosed with dissociative disorder to find out structure and functions of personality, psychological development, coping, identity, symptom formation and cognitive functions. The routine psychiatric assessment with psychological examination was considered enough in 3 patients to confirm the clinical relevance of dissociative symptoms for the functional capacity of the patient and the specific diagnostic criteria of a dissociative disorder. Still, in 8 of the patients, a visual expression interview was requested as a complementary method of assessment to obtain an accurate diagnosis or to build up sufficient communication with the patient to establish the diagnosis (Table 3).

The dissociative experiences were illustrated in several ways and with personal uniqueness by each patient at the visual expression interview, but still, some examples can be given as follows: 1. Fading away of painful images or numbing was depicted sometimes by elements of white emptiness surrounding a restricted spot of awareness, sometimes by gloomy floating clouds or dull grey fog covering more lively, affective colours. 2. Chaotic, intensive and partially disconnected emotions, emotional stimuli and hyperarousal described by messy and intensive colours painted or scribbled with an abstract disorganized form, or like coiled threads with no ends. 3. Detachment from the self or from environment sometimes expressed like being surrounded by a thin, transparent membrane or a shell, or floating inside a bubble. 4. Traumatic experiences sometimes approached and alienated by depicting concrete, random small details and perceptions related to the place of traumatic event, and sometimes by using very distant or reduced symbols, or non-personal substitutes. 5. Somatic dissociative experiences can be expressed as disproportionate or alienated body parts. Besides, the subjective interpretation of dysfunctional body system with its personal meanings and explanations become visible. 6. The alterations of identity may sometimes become visible by depicting different parts of identity. This can happen spontaneously, reacting to any stimulus during the interview, or to a specific task, like focusing on certain time periods. The visual expression of different identity parts or states may also occur consciously, as a product of more elaborate self-reflection and sufficient feeling of safety to immerse in a creative process.

In assessment of ability to work, the primary diagnosis used is the most important factor accounting for the disability. The dissociative diagnosis was defined as the main diagnosis in less than half of the cases (Table 3). The dissociative patients that were assessed to be permanently or long-term disabled (more than half a year) had other comorbid disorders that mainly accounted for the disability or severely hampered the rehabilitation of dissociative disorder.

New treatment or rehabilitation plans were found for most of the dissociative disorder patients, according to new diagnoses and knowledge about functional capacity (Table 3). Most of the patients were recommended new psychotherapeutic approaches, new interventions for 10 of them, and modifications to current psychotherapy for one. One year after assessment, 11 of the patients were reached by telephone and interviewed by a project employee. Nine of them gave positive feedback, 5 of them being satisfied with the assessment and one with the outcomes of her rehabilitation plan. Three patients gave negative feedback, two about outcomes (economic and having no access to psychotherapy), whereas one patient was frustrated with the assessment. She had the experience of telling again and again her story for everyone. This patient had only the routine clinical assessment and no visual expression interview.

**Table 3.** Patients in psychiatric visual expression interview with end dissociative diagnoses. Rationale for "Relationship to self" interview for patients, the focus of questions and type of new information that was obtained from the interview and its contribution to diagnosis are presented. Dissociative diagnoses are marked in bold font. The end diagnoses are listed in priority order according to their effect on disability in the context of work ability assessment. Work trial and supported employment are forms of vocational rehabilitation. CBT is cognitive behavioural therapy.

Diagnosis at referral	End diagnosis	Visual expression interview/ findings	New treatment or rehabilitation plan	Ability to work (short-term <1/2 year)	Vocational status after one year	Feedback after one year from assessment
F33.3	F33.2, <b>F44.88</b> , F41.0	<b>Not needed</b>	None	Permanent disability	New sick leave, not working	Frustrated of retelling her story again and again
F41.1, F33.1	F32.10, <b>F44.88</b>	<b>Not needed</b>	Psychotherapy continuation Work trial	Short-term disability	Working	Happy to get psychotherapy
F06.6, F45.2	F32.20, <b>F44.5</b>	<b>Yes/visibility</b> of deeply depressive and suicidal ideas, masked by cultural factors. Disconnections in awareness, conversion	Art psychotherapy rehabilitation Antidepressant	Long-term disability	No disability benefits, but unable to work	Unhappy with getting no psychotherapy. Suicide attempt.
F33.0, F41.0, F43.1, F42.1	<b>F44.88</b> , F43.1, F41.0, F42.2	<b>Yes/ dissociative</b> aetiology of severe amnesia. Primary role of dissociative amnesia and PTSD for disability	Psychiatric care CBT treatment Supported employment	Partially disabled	Work trial Part-time disability pension	Part-time disability pension is economically no good for unemployed.
R41.8, F32.1, F41.0	F32.20, <b>F44.88</b> , F34.1, F41.0	<b>Yes/ dissociative</b> mechanisms behind severe amnesia, not explained by depression alone	Trauma therapy New medication	Permanent disability	Disability pension	-
F32.1	F33.20, <b>F44.88</b> , F40.1	<b>Not needed</b>	Trauma therapy Psychiatric care	Long-term disability	No information, was not reached by phone	-

Diagnosis at referral	End diagnosis	Visual expression interview/ findings	New treatment or rehabilitation plan	Ability to work (short-term <1/2 year)	Vocational status after one year	Feedback after one year from assessment
F33, F41.9, F60.31	F43.1, <b>F44.8</b> , F33.01, F60.31	<b>Yes</b> /the primary trauma aetiology behind symptoms, chaotic intensive emotions and over-arousal	CBT rehabilitation New medication	Long-term disability	Unemployed	Grateful for having been heard at the assessment
F31.8, F61.0	<b>F44.8</b> , F60.8	<b>Yes</b> / alterations of identity and disconnected phases of personal history	Trauma oriented art psychotherapy	Long-term disability	Voluntary working on rehabilitation allowance. Work trial interrupted	Recovering slowly with therapy, but treatment intensity is limited due to rejection of reimbursement
<b>F44.7</b>	<b>F44.7</b> , F33.8	<b>Yes</b> / controversial roles and no escape from distress. Functional symptom formation, conversion became understandable	Somatosensory psychotherapy rehabilitation Work trial	Long-term disability	Not working, rehabilitation allowance. Trying to return to work	Very satisfied with the assessment and the encounter
F31.4	F31.4, F41.0, F60.31, <b>F44.8</b>	<b>Yes</b> / uncontrollable, intrusive traumatic images and their association with amnesia and detachment	Occupational therapy, CBT New medication	Long-term disability	Not working, rehabilitation allowance	Assessment and treatment plan was found useful
F33.11, F34.1	<b>F44.88</b> , F41.1, F32.11	<b>Yes</b> / Psychological distress and reactions to it were identified	Psychiatric care, short CBT, Work trial	Short-term disability	Not yet working, but aiming at work. Rehabilitation allowance	Relieved for finding the reason, satisfied for being well assessed
F34.1	<b>F44.7</b> F33.11, F41.1, F61	<b>Yes</b> / Triggers and mechanisms behind amnesia and other cognitive symptoms	Modifications in psychotherapy and medication	Long-term disability	Working	Assessment was found useful
TOTAL 1 patient with F44 diagnosis	TOTAL 5 patient with F44 as main diagnosis	TOTAL 9 patients who underwent the visual expression interview	TOTAL 11 patients with new treatment or rehabilitation plans	TOTAL 9 patients with long-term /permanent disability	TOTAL 2 at full-time work 2 part-time/ rehabilitative work	TOTAL 9 comments 6 positive: 5 about assessment 3 negative: 1 about assessment



## Case description "in the fog"

An academic student in her thirties was referred to diagnostic re-evaluation and assessment of ability to work after a long-term decrease in function and interrupted studies. The referral diagnosis was F34.1. The patient had a history of functional somatic symptoms since childhood, possibly precipitated by an insecure childhood and somatic illness of another sibling. During college, she started to experience increasing problems with memory and learning new and integrating experiences. She felt tired, overwhelmed and emotionally detached. The consulting psychologist at the college considered the symptoms to be related to stress and anticipation of graduation.

Later, the possible organic aetiology was excluded by neurological and neuropsychological examination that revealed a high level of cognitive function, with possible mild mood-related fluctuation. There were clinical depressive episodes with no treatment response to standard medications and psychotherapeutic interventions in the medical history. Instead, the patient reported some tranquilizing effect from physical relaxation exercise. During the last few years her studies were severely hampered, and finally interrupted by difficulties to learn and remember.

In the present psychiatric examination, the patient reported mild depressive and anxiety symptoms, but she made a more severely affected impression. She seemed fragile, and much younger, sitting in a coiled position, like protecting herself. Her narration was repeatedly interrupted, and her voice turned very quiet from time to time, just whispering and she had tears in her eyes. She scored 24% on DES.

In the visual expression interview she was mentally present more continuously than in routine interview, and she engaged in visual expression, working fluently, with no interruptions. She described her self-experience by painting grey fog, that covered her all over so that she could not be seen, not even by herself, as she explained. To her, the fog represented detachment, loss of concentration and a diffuse state of mind. While looking at the painting, she was able to verbalize her feelings of alienation and being strange to herself.

Behind the fog, she explained, there were glimpses of feelings, yellow light related to affection, trust and joy that she could sometimes experience with her closest friends. She pointed out that there were black spots too, representing her negative

feelings. She explained that she was occasionally able to reveal them to her friends, and that she had the courage to face those feelings when she had someone around to share and trust. The lowest part of the picture was covered by the thickest fog, which she described as symbolizing the spilling of the distant, alienated feeling into contacts and situations with her friends as well, leading to withdrawal on her part. This was an experience that made her feel inconsolable, and she seemed apparently sad when talking about it. She associated the feeling with her childhood experiences, when she was afraid to say something wrong.

The memories of fear and shame were so painful, that she had been rejecting them since they re-emerged after her trip abroad that opened her eyes, as she said. She did not report feeling depressed, but rather sad, tired and distant, like walking alone in the fog, sometimes seeing those glimpses of colour that anchored her feelings, and made them visible.

The patient agreed with the dissociative character of her functional amnesic symptoms that seemed to be a maladaptive response to protect her from psychic pain. As painting was pleasurable for the patient, giving a sense of getting in touch with her own feelings, and physical exercise relieved her anxiety, she was interested in restarting her artistic and physical exercise well-being activities. She was going to continue her current psychotherapy with some modifications, taking into account the dissociative disconnections between her feelings and awareness. At one-year follow-up, she still could not go on with her studies, but she was working for a while.

## **Case description "falling into transparency"**

A skilled manual worker in her early forties was referred to assessment of work ability after having been away over 10 years from working life. After chronic illness and long-term disability, a permanent disability pension was to be considered unless some rehabilitation options could be found. Her referral diagnosis was bipolar mood disorder, type 2 (F31.8). She had a heavy history of hospitalizations, multiple psychiatric symptoms and comorbidity. The last few years she had been able to take care of herself, and her closest ones, but all her energy was consumed by carrying out her daily activities and responsibilities, and trying to act as normal as possible. The disciplined daily routines helped her to manage with her daily life. She had shown no treatment response to mood stabilizers and during the past year she had been without medication. There was no change in her symptoms or functioning since withdrawal of medications.

She described her current symptoms and function in a vague manner in the diagnostic interview, as well as at the preceding assessment appointments. She had difficulties to find answers to questions, and when she tried to hold on to some ideas or feelings to describe, she suddenly lost them and felt just emptiness. She made an effort to maintain contact with the interviewer, but she often became distant, locked and embarrassed, often giving answers like "maybe", "I do not know", or "I do not have words for that". At the time no significant mood symptoms were observed, nor reported by the patient. Instead, she presented with amnesia, diffuse awareness of herself and her surroundings, sudden disconnections in her thinking, numbing of affect, fluctuating anxiety, emptiness and frustration about not being able to feel and express herself. The DES score was 33%.

The visual expression interview was performed together with a clinical psychologist, by her initiative, because of the minimal verbal communication and contact that hampered the psychological examination. The goal was to offer the patient an alternative way to express herself, and to build up a personal life history, which was difficult with the fragmented pieces of memories and no contact with relatives. She was asked to depict herself, the way she was at different ages (she was not able to recollect memories about how she experienced herself in the past, but she tried to form an image of her past self retrospectively).

When describing herself as a child, she left the paper blank, except that she painted a little black spot in the middle. She explained that she had no idea of herself as a child, as if she had never been a child, or maybe somebody else, a strange kid. She said that she remembered nothing about childhood (white blank paper), but only fear came to her mind (the black spot). She became anxious and she put aside the picture for a while. Soon she took it back, and started to talk, looking at the picture. She said it was better to be very little and unnoticeable (pointing the black spot again) because of the threatening atmosphere. She was wondering if the danger of violence was true, and if there really was a "threatening with an axe" or not. Despite ambiguous recalling of events, she was able to recognize and face her feeling of fear that she had tried to forget and escape.

She described herself in adolescence as a small figure, hiding behind a pony that was bringing safety to her. Again, the paper was left white and empty, except for the small figures in the middle. The girl had no eyes or mouth. The patient explained that she had deliberately left them unpainted, symbolizing that it was not allowed to see or to talk about some painful events in the childhood family. When proceeding to her

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current self, she filled the left part of the paper with lively colours, painting vigorously a big and aesthetically elaborate self-portrait, with an obvious resemblance to her, but with a happier expression. She left the right side of the paper almost empty, but painted there a tiny very pale figure with almost no colour at all, leaving an impression of a drop of unclear water at first sight. When looking closer, quite a diffuse and very transparent human figure could be seen. She described these two figures as her two alternating states: "the strong, adult person who has to manage her life", and "the vulnerable and weak, undeveloped figure without a protecting skin and without boundaries". She said that the latter "can only survive and develop in a test tube". She described how she sometimes fell into that vulnerable transparency, painful with no skin, and totally helpless and invisible to others. She explained that this part of her personality had even been invisible to herself until the last year she had started to become conscious of it.

The picture of herself in the future was optimistic; instead of two different parts she described herself as a whole figure. The figure could be of any age, a little illusory and fairylike, but having a face and a smiling expression, moving forwards, towards the spectator. After making these pictures, the patient felt more capable of expressing herself and less embarrassed about the changes in her state, being relieved by them becoming visible. She became more optimistic about her future treatment and recovery. She felt that the former diagnosis of bipolar disorder did not correspond to her experience, and she was relieved to adopt the dissociative mechanism as a major explanation for her symptoms. There was no evidence of hypomanic episodes from previous patient files, nor from clinical examination. Instead, it seemed that her affective instability, post-traumatic over-arousal, dissociative switches in behaviour and past drug abuse had been interpreted as hypomanic episodes. In the absence of diagnostic criteria, the bipolar diagnosis was removed.

As the visual expression was natural to her, aiding to establish contact and to tolerate uncertainty and anxiety, she was interested in art psychotherapy. She made considerable efforts to start the therapy, and continued for one year with no reimbursement from National insurance. At one-year follow-up she was feeling better, and she actively tried to return to employment. There was one unsuccessful work trial due to insufficient remission, but she was able to do some voluntary work. The therapy frequency, that she could afford, was subtherapeutic (1 or 2 times a month).

## Discussion

The visual image interview contributed to most of the new functional diagnoses, and in particular to the dissociative diagnoses. The low prevalence of dissociative disorders in the referred patient sample (< 1%) compared to the more frequent dissociative diagnoses (9%) of the same patient sample after a profound psychiatric examination seems to reflect the tendency for underdiagnosis of dissociative disorders. The patients diagnosed with dissociative disorder by a profound clinical assessment had earlier been most often treated for mood disorder diagnoses without treatment response. After a correct diagnosis, they got new treatment and rehabilitation plans that were focused on their predominant psychopathology.

At one-year follow-up, there were disconnections in treatment, rehabilitation or social security benefits with half of the dissociative patients. The prognosis and return to work goal for one of the patients was seemingly underestimated by the municipality, leading to a rejection of psychotherapy rehabilitation reimbursement with an explanation referring to premature timing. Another patient's functional capacity was possibly overestimated by the rejection of rehabilitation allowance, or this may be a consequence of disconnection in psychiatric care. Dissociative patients seem to need continuous care and case management in order to be able to engage in treatment and rehabilitation successfully.

The functional prognosis of dissociative patients is more difficult to predict than that of mood disorders. It seems clear, however, that more severe comorbidity is associated with a worse prognosis and more disconnections in care. The severity and multitude of dissociative symptoms also seems to predict a less favourable outcome. According to one Finnish population study, the patients with both high psychological and high somatoform dissociation often had comorbidity with depressive symptoms and suicidal ideation. They also had cumulative problems with working ability, general health and socioeconomic situation (39).

There are psychotherapeutic treatments and interventions for patients with dissociative disorders that aim at integrated functioning, but the evidence, availability and standard guidelines are scarce compared to mood disorders and PTSD. Phase-oriented treatment approach (similar to complex PTSD) is suggested while tailoring of the treatment individually is emphasized (40). There are no specific psychopharmacological interventions for dissociative disorders, but treatment is often needed for comorbid psychiatric disorders and sometimes to relieve anxiety and affect dysregulation.

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The diagnoses were based on ICD-10 criteria, that are officially used in Finland, but the diagnostic data and differential diagnostic information was obtained from SCID and many other sources, such as family interviews, earlier medical records and psychological examination in addition to the visual expression interview. Unfortunately, no gold standard of diagnosing dissociative disorders was available, because SCID-D was not available in Finnish, and DES is only a screening method. With DES, many of the patients found it difficult to report percentages of time as their retrospective images, self-monitoring and sense of time were discontinuous. The best diagnostic accuracy could be obtained by using SCID-D or similar semi-structured interviews, whereas the complementary role of visual expression interview is emphasized with patients that are verbally scarce or incoherent.

According to referral criteria, the questions of function and disability were complicated and controversial in our selected sample, thus the frequent need for complementary assessment techniques is probably not generalizable to general psychiatric outpatient clinics. However, if there is some art therapy training and orientation in the psychiatric team, giving 1.5 hours of extra time for a visual expression interview and making a modest art material investment, this may be helpful in psychiatric assessment to enhance self-reflection and visibility of psychological problems as well as resources. Offering optional ways to express sensitive or hard to verbalize experiences for the patients can be considered a client-oriented approach. To obtain optimal benefits and to know the limits and to create safe frames when interviewing severely traumatized patients, psychiatric or psychotherapeutic skills are needed and education in art therapy techniques are helpful.

The visual expression interview was accepted and appreciated by the dissociative patients of our study sample. None of them refused and the feedback was positive, they were satisfied with the usefulness of assessment and the way they were encountered. Combining the visual expression interview in psychiatric interview seemed to enhance the communication and self-expression of patients with limited verbal expression or disconnections in self-perception, cognitive or emotional processing, and in maintaining contact with the interviewer. This additional method also helped to focus the discussion more efficiently on areas of inspection, even sensitive ones, like those related to trauma, body integrity, unusual perceptions and fear of madness. The clinical assessment of the dissociative patients included psychological examination but still, the visual expression interview was considered as a useful complementary assessment method with most of the dissociative patients.

As dissociative disorders are characterized by disconnections in awareness, emotions and perceptions, a new diagnosis is not always welcomed and understood by the patient. This is particularly problematic in cases of a somatoform diagnosis, somatic dissociation and mainly somatic symptoms. This project, however, showed that the new functional diagnosis is more acceptable and understandable for the patient, if he or she has been elaborating the material and conclusions behind the diagnosis in mutual understanding with the clinician. To become seen and heard as oneself is sometimes easier with multiple channels for self-expression with a safe atmosphere that opens new dimensions for discussion and awareness.

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