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Degree of dissociativity in the inpatient population of a hospital in northwestern British Columbia

More than two-thirds of patients in a small psychiatric unit were found to have a diagnosable degree of dissociation.

ABSTRACT:

Background: **Dissociative disorders are characterized by disturbances in the functions of identity, memory, consciousness, or perception of the environment. There is scant evidence of the prevalence of dissociative disorders in rural and remote areas in Canada.**

Methods: **During a 1-month period, all inpatients who had spent at least 48 hours in the unit were assessed using three diagnostic questionnaires: the Dissociative Experience Scale, the Somatoform Dissociation Questionnaire, and the Dissociative Disorder Interview Schedule.**

Results: **More than two-thirds (69%) of patients had clear evidence of a diagnosable degree of dissociation. The most common concomitant diagnoses were borderline personality characteristics and depression.**

Conclusions: **This small study suggests a high prevalence of dissociation among psychiatric patients in a rural and remote area; more studies are needed to confirm this result.**

Background

The goal of a research project initiated in December 2000 was to determine the level of dissociativity in the inpatient population of the psychiatric unit at Mills Memorial Hospital in Terrace (northwestern British Columbia). Dissociative disorders are characterized by disturbances in the functions of identity, memory, consciousness, or perception of the environment.

Methods

During a 1-month period, all inpatients who had spent at least 48 hours in the unit were assessed using three diagnostic questionnaires: the Dissociative Experience Scale (DES), the Somatoform Dissociation Questionnaire (SDQ-20), and the Dissociative Disorder Interview Schedule (DDIS). The DES and SDQ-20 were completed by the patient independently, and the DDIS was administered by an interviewer.

The Dissociative Experience Scale was devised by Drs Frank Putnam and Eva Carlson, both of the National Institute of Mental Health (NIMH) in Bethesda, Maryland. The DES is one of the oldest and one of the most useful questionnaires. Many of the 28 questions concern very common experiences, such as driving down the highway and forgetting to turn off at the proper place; some, however, are not so common and indicate a higher than average capacity for dissociative experience. A score of 20 or more indicates considerable capacity for dissociative experiences (although this in itself is not a diagnosis). A score of 30

Dr Hunter was a family physician in West Vancouver from 1972–1989. At that time, her work with clinical hypnosis and trauma disorders, especially dissociative disorders, threatened to overtake her family practice so she diverted into full-time psychotherapy work, focusing on trauma-spectrum problems. She is a past president of the BC College of Family Physicians, the American Society of Clinical Hypnosis, the Canadian Society of Clinical Hypnosis (BC Division), The International Society for the Study of Dissociation, and a past National Co-Chair of the Canadian Society for Studies in Trauma and Dissociation. She had been an assistant clinical professor in the Department of Family Medicine for many years before moving to Victoria in 1999. She is currently the director of the LabyrinthVictoria Centre for Dissociation.

Table. Results of psychiatric assessment of inpatients at a northwestern BC hospital using three diagnostic questionnaires.

Patient	Gender	Age	Admitting diagnoses	Score on DES*	Results of SDQ-20†	Major trends indicated by DDIS‡
1	Female	27 years	Depression; borderline personality disorder	21	Only a few indications of somatoform symptomatology	Posttraumatic stress disorder; dissociative disorder NOS (not otherwise specified); dissociative fugue; borderline personality characteristics
2	Female	32 years	Borderline personality disorder; chronic depression; anxiety	59	Moderate indications of somatoform symptomatology	Tendency to somatization; major depressive disorder; features of borderline personality disorder; dissociative disorder NOS; dissociative identity disorder (DID) ruled out
3	Female	46 years	Depression; anxiety and panic attacks	97	Moderate indications of somatoform symptomatology	Dissociative disorder NOS; depression (probably episodic); borderline personality features
4	Female	22 years	Possible adult attention deficit disorder; possible obsessive-compulsive disorder	15	No evidence of somatoform symptomatology	Major depressive episodes
5	Female	48 years	Bipolar disorder; schizoaffective disorder	57	Moderate somatoform symptomatology	Major depressive episodes; dissociative disorder NOS; DID ruled out; borderline personality disorder; very low score on Schneiderian First Rank Symptoms
6	Female	38 years	Posttraumatic stress disorder; borderline personality disorder; schizoid disorder	60	More than moderate somatoform symptomatology	Major depressive episodes; high score on Schneiderian First Rank Symptoms; borderline personality disorder; high score on features associated with dissociative disorder
7	Female	26 years	Borderline personality disorder	48	Mild somatoform symptomatology	Patient left the hospital against medical advice before completing the DDIS
8	Male	57 years	Anxiety disorder	20	No indication of somatoform dissociation	Moderate depression; borderline personality characteristics
9	Male	26 years	Anxiety; depression; paranoid thoughts	70	Considerable somatoform symptomatology	Tendency to somatization; major depression disorder; major dissociative symptoms; probable DID
10	Male	36 years	Major depression with psychotic episodes	Less than 5	No somatoform symptomatology	Major depression; fits the NIMH criteria for probable DID, denied having Schneiderian First Rank Symptoms and answered “no” to most of the question regarding dissociative symptoms
11	Male	15 years	Attention deficit hyperactivity disorder; anger management problems	26	No somatoform symptomatology	Depression; features of major dissociative disorder; DID ruled out; borderline personality disorder
12	Male	43 years	Chronic clinical depression; obsessive-compulsive disorder; mood disorder	5	No somatoform symptomatology	Major depression; borderline personality characteristics

* Dissociative Experience Scale
† Somatoform Dissociation Questionnaire
‡ Dissociative Disorder Interview Schedule

or more indicates intrusion of dissociative experiences into day-to-day functioning.

The Somatoform Dissociation Questionnaire was devised by Dr Ellert Nijenhuis and his colleagues in the Netherlands. It assesses the 20 somatic symptoms more commonly found in patients with a history of trauma, especially trauma during childhood. People who experience these symptoms without medical cause on a regular, frequent basis are more likely to have a somatoform type of dissociation.

The Dissociative Disorder Interview Schedule was devised by Dr Colin Ross and his colleagues when Ross was head of the Dissociative Disorder Unit at St. Boniface General Hospital in Manitoba. It is a very lengthy questionnaire designed to differentiate between possible diagnoses, such as schizoaffective disorders and bipolar disorder, while at the same time assessing for dissociation. It is not as lengthy as the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) but is usually just as useful and less time-consuming. It is particularly helpful for ruling out dissociative identity disorder (DID).

Results

Twelve patients were assessed (seven females and five males). One female patient left the hospital against medical advice and did not complete the DDIS. The assessment results for all the patients can be seen in the accompanying **Table**.

Of the 12 subjects, four had low scores on the Dissociative Experience Scale (20 or less). We would expect, therefore, that they would be unlikely to have the symptoms of dissociative disorders. This, in fact, was the case. A fifth patient scored just above the level of 20 and was described as having dissociative disorder NOS (not otherwise specified) symptomatology, and a sixth was described as having "features of a major dissociative disorder."

Interestingly, from there the scores jumped to very high levels in the remaining six patients, all of whom displayed major dissociative symptoms.

On the Somatoform Dissociation Questionnaire, all patients who exhibited DES scores of more than 30 scored "moderate" to "considerable" on somatoform dissociation symptoms; the one exception was the patient who left the hospital.

On the Dissociative Disorder Interview Schedule, seven patients had features indicating a major dissociative disorder; of these, all had DES scores above 20. Both the SDQ-20 and DDIS results suggest that the Dissociative Experience Scale is a useful screening tool for the diagnosis of a dissociative disorder.

The most common concomitant diagnoses were borderline personality characteristics and depression.

While this is a very small study, it is noteworthy that more than two-thirds (69%) of patients had clear evidence of a diagnosable degree of dissociation. It is equally interesting that those who scored very low on the DES had no discernable dissociative characteristics.

Conclusions

Physicians who work or have worked extensively in the North are already aware of the prevalence of dissociativity in mental health patients. It is not hard to understand why, given the preponderance of residential school syndrome, depression, suicidal ideation (especially, but not limited to, the young), family violence, sexual assault, and alcohol and drug abuse. Add to this the social isolation, challenging climate, major seasonal changes in hours of light and dark, poor employment opportunities, and the long distances from many medical services and mental health care services.

Dissociative disorders are characterized by disturbances in the functions of identity, memory, consciousness, or perception of the environment.

Similar studies need to be undertaken in other northern, rural, and isolated regions. Should the results replicate those described here, then the message will be clear. We must find solutions (which inevitably require money and trained people) for underserviced areas.

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Competing interests

None declared. BCMJ