ASSESSMENT OF CHILDHOOD TRAUMA AND DISSOCIATION IN AN EMERGENCY DEPARTMENT

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ABSTRACT

A sample of 774 psychiatric emergency room consultation reports at a teaching hospital were reviewed to determine how often childhood trauma and its long-term sequelae were enquired about. It was evident that trauma and its sequelae were not enquired about systematically during emergency room consultations.

INTRODUCTION

Briere and Zaidi (1989) recently found that the rate of reported childhood sexual abuse among female psychiatric emergency room patients was 6% when assessed by retrospective chart review, but increased to 70% when staff were instructed to enquire about childhood sexual abuse in every case. They observed strong positive correlations between the severity of childhood sexual abuse and clinical variables, including suicide attempts and number of prior psychiatric diagnoses.

Because of our interest in childhood trauma and multiple personality disorder (Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990), we decided to replicate the retrospective component of Briere and Zaidi's study and to enquire in addition about the assessment of dissociative symptoms and disorders in an emergency department.

METHOD

A sample of emergency room consultations by psychiatric on-call staff at St. Boniface Hospital, Winnipeg, Manitoba, was reviewed for the period July 1, 1985 - June 30, 1991. Consultation reports are filed alphabetically: files under every fourth letter of the alphabet (beginning with the letter 'A') were reviewed by a psychiatric research nurse. Most consultations at this hospital are done by the psychiatry resident on call, with the staff psychiatrist providing telephone back-up. All cases were discussed with the staff psychiatrist prior to disposition.

For each consultation the following information was tabulated: gender and age of patient; year of consultation; whether a dissociative disorder was diagnosed; whether borderline personality disorder was diagnosed; whether childhood physical and sexual abuse were noted to be present, noted to be absent, or not commented on; and whether amnesia, auditory hallucinations, depressed mood and suicidal ideation were noted to be present, absent, or not commented on. Data were analyzed descriptively.

RESULTS

A total of 774 cases were reviewed, of which 325 (42.0%) were males and 58.0% were female. The median age was 34 years and the range was 12 - 98 years. The number of consults per calendar year were: 1985 - 51; 1986 - 107; 1987 - 101; 1988 - 128; 1989 - 168; 1990 - 144; 1991 - 61. Year of consultation was not tabulated in one case.

The primary psychiatric diagnosis could not be determined from the consultation report in 33 cases: of the remaining 741 cases, 70 (9.4%) had a primary diagnosis of schizophrenia; 71 (9.6%) other psychosis; 80 (10.8%) bipolar mood disorder; 177 (23.9%) another mood disorder; 35 (4.7%) a personality disorder; 12 (1.6%) a dissociative disorder; 117 (15.8%) an adjustment disorder; and 179 (24.2%) some other disorder. A dissociative disorder was either a primary or secondary diagnosis in 22 (2.8%) cases. Borderline personality disorder was diagnosed in 64 (8.3%) cases.

The number of cases in which childhood trauma, amnesia, auditory hallucinations, depressed mood and suicidal ideation were enquired about are shown in Table 1.

DISCUSSION

Our data replicate Briere and Zaidi's (1989) study, in which childhood sexual abuse was noted in only 6% of psychiatric emergency cases by retrospective chart review. In 87.6% of the psychiatric emergency room consultations in our sample, a history of childhood sexual abuse was not commented on in the consultation report. Childhood sexual abuse was said to be present in 8.0% of cases in our sample.

This finding is noteworthy because the senior author had presented grand rounds in this Department of Psychiatry, had given resident seminars, and had published on childhood trauma and dissociative disorders throughout the study period. One might therefore expect a high index of suspicion for childhood trauma and its long-term sequelae in residents on call in this department.

TABLE 1
Frequency With Which Childhood Trauma and Its Sequelae Were Enquired About in 774 Emergency Department Psychiatric Consultations

	Present	Absent	Not Commented On
	%	%	%
Childhood Physical Abuse	6.0	4.4	89.7
Childhood Sexual Abuse	8.0	4.4	87.6
Depressed Mood	38.1	32.6	29.3
Suicidal Ideation	24.8	48.6	26.6
Auditory Hallucinations	13.7	25.1	61.2
Amnesia	3.0	0.9	96.1

Depressed mood was not commented in 29.3% of the emergency room consultations, and suicidal ideation was not commented on 26.6% of the time. However, both these key clinical features of patients in psychiatric crisis were enquired about far more frequently than auditory hallucinations, which were not commented on in 61.2% of cases. Amnesia was not commented on in 96.1% of cases.

Since suicidal ideation, depressed mood, auditory hallucinations, and amnesia can all be long-term sequelae of childhood trauma, it is evident that this dimension of psychopathology is not being systematically assessed and documented by psychiatry staff on call at this hospital. Dissociative disorders were diagnosed in only 2.8% of cases, although the minimum frequency of dissociative disorders among psychiatric inpatients at this hospital is 20.7% (Ross, Anderson, Fleisher, & Norton, 1991). It is evident that substantial dissociative symptomatology is missed in the emergency department.

There is no reason to think that childhood trauma and its long-term sequelae are assessed less systematically at St. Boniface Hospital than elsewhere in North America, therefore the findings from our study are likely representative of North American emergency room practice. Several brief case vignettes from the sample give a sense of the lack of systematic assessment for childhood trauma and dissociation.

Case 1: A seventeen-year-old girl was referred by a school counsellor after doing a drawing at school depicting wrist slashing. She gave a history of a "black" and a "white" voice arguing in her head for the last three years, accompanied by chronic suicidal ideation. She had been functioning at a high level at school. She remembered her father taking off his and her clothes at age eight, but does not recall what happened after that. A dissociative disorder was not mentioned in the differential diagnosis.

Case 2: A twenty-one year-old woman with 30 suicide attempts in the last year (including jumping from a car and trying to slit her throat) said she remembered all these attempts but had no control over them. She was quoted as saying, "Part of me wants to kill myself and the other part says no." She described a male and a female voice in her head. Childhood trauma was not commented on, but dissociative disorder was included in the differential diagnosis.

Case 3: A forty-six year-old woman was seen following an overdose. Dissociative disorder was listed as a possible diagnosis but no trauma history or dissociative symptoms were described in the consultation report.

Case 4: An eighteen-year-old male had a history of impulse control disorder since his mother died four years previously. He claimed amnesia for his violent episodes and gave a history of childhood sexual molestation. Dissociative disorder was included in the differential diagnosis but auditory hallucinations were not commented on.

Case 5: A twenty-year-old male sought help for alcoholism. He described three distinct types of blackouts, only one of which he felt was related to alcohol. He had been drinking since age four, and had chronic voices inside his head commenting on his actions. He stated that his mother's friend who works on a psychiatric ward had diagnosed him as having "multiple personality syndrome." Childhood trauma was not commented on, and multiple personality disorder was included in the differential diagnosis.

The most likely reason for the under-diagnosis of dissociative disorders and other long-term sequelae of childhood trauma is lack of a conceptual framework to guide such enquiry, with consequent failure to ask the relevant questions. As illustrated in the Table and the case vignettes, the key elements for diagnosis of multiple personality disorder are not enquired about systematically. In one case, auditory hallucinations and amnesia may be documented with no comment on childhood trauma, while in another, childhood sexual abuse and voices are described but there is no enquiry about amnesia.

Multiple personality disorder is the most complex and chronic long-term sequela of childhood trauma. Elements of the disorder can be present in other dissociative disorders or as symptoms in patients with no dissociative disorder (Putnam, 1989). These elements should be enquired

about routinely within a conceptual framework that acknowledges this disorder and its etiology, allowing the interviewer to relate these otherwise seemingly disparate features to the unifying theme of trauma and consequent dissociation. ■

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