COMMENTARY

DID in resurgence, not retreat

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COMMENTARY ON… Dissociative identity disorder[†]

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SUMMARY

Contrary to the assertion of Paris, diverse indicators suggest that the diagnosis and treatment of dissociative identity disorder (DID) are resurgent rather than retreating. This commentary reviews the evidence that justifies the description of this condition as controversial, including research into dissociative amnesia. The potential harm that can result from a diagnosis of DID and risky treatment techniques, including hypnosis and abreaction, are described. It is suggested that this scientifically unproven and potentially harmful treatment model should be confronted and quelled and its diagnosis and treatment subjected to critical clinical review, including randomised controlled trials, as a matter of urgency. A plea is made for the Royal College of Psychiatrists to update its 1997 guidance document and for professional training to incorporate updated psychological and neurobiological research on human memory.

DECLARATION OF INTEREST

None.

KEYWORDS

Dissociative disorders; psychiatry and law; trauma; childhood experience.

[†]See this issue.

> 'When ideas go unexamined and unchallenged for a long time […] they become mythological, and they become very, very, powerful'
>
> (E. L. Doctorow)

We endorse Paris's timely article on dissociative identity disorder (DID) (Paris 2019, this issue) but contend that the disorder is far from moribund. Although a dearth of reliable research data prevents accurate assessment of its current prevalence, diverse indicators suggest that its diagnosis and treatment are resurgent rather than retreating. As Paris notes, the DID diagnosis treatment model is contentious, endorsing therapeutic methods recognised as potentially harmful (Lilienfeld 2007). Also, the efficacy of the treatment model is unproven and not empirically supported. Significantly, prior to treatment, DID patients typically *do not* initially present with any 'alters' or other 'selves' and have no knowledge of previous sexual or other trauma. The unique diagnostic hallmark, namely 'alters', typically emerges *during treatment*, juxtaposed with increased mental distress in the form of dissociative episodes and self-harm. We contend that instead of 'hop[ing] that the construct will eventually wither from disinterest' (Paris 2019), this scientifically unproven and potentially harmful treatment model should be confronted and quelled and its diagnosis and treatment subjected to critical clinical review, including randomised controlled trials, as a matter of urgency.

Re-emergence and growing acceptance of DID

In the 1990s, numerous malpractice actions against US psychiatrists by their former DID patients – 'retractors' – resulted in multi-million-dollar settlements. Freed from therapy, retractors' health improved and they rejected their 'memories' of sexual abuse (Pendergrast 2017). Yet, despite the negative exposure, accumulated research data and well-founded academic criticism refuting any evidence for a mechanism capable of causing massive memory repression (dissociative amnesia), DSM-5 (American Psychiatric Association 2013) has further embedded and legitimised this controversial diagnosis. In the USA, DID is being promoted via conferences, social media, films and books (Pendergrast 2017), a trend echoed in the UK, where the Official Solicitor and a borough council unsuccessfully sought an interim injunction to prevent the broadcast of a film about a woman with an intellectual disability and DID (*E v Channel Four Television Corp* [2005]). Since 2011, DID advocates in the UK have campaigned for better recognition of DID (Bowlby 2014). There are now four private UK clinics for DID patients and two charities raising awareness via conferences and professional training. National Health Service (NHS) trusts are facilitating and funding often expensive DID treatment. In *St Helens Borough Council v Manchester Primary Care Trust* [2008], the court bemoaned the fact that two publicly funded bodies had become engaged in expensive litigation to decide which should pay £675 000 per annum for the care of a woman with DID who had been having weekly psychotherapy for over 8 years. However, guidance (a) warning the public

of the potentially adverse impact of treatment, (b) cautioning therapists of the attendant therapeutic risks or (c) acknowledging the implications and need for informed consent is absent.

A flawed memory mechanism, treatment model and the potential for serious harm

Paris recognises that '[o]ne of the central ideas behind DID, the repression and/or dissociation of traumatic memories, has never been accepted by memory researchers'. Memory researchers and clinicians have unsuccessfully searched for evidence in support of this mechanism. Moreover, decades of psychological research contraindicate dissociative amnesia as a mechanism (Brandon 1998; Piper 2008). An empirical study specifically using verified childhood sexual abuse also contradicts it (Alexander 2005). Dissociative amnesia/DID sceptics agree that trauma may cause depersonalisation and memory errors but contend that there is no evidence for dissociative amnesia – even though it is now embedded in the pantheon of diagnoses in DSM-5 (Patihis 2019). They observe that dissociative amnesia requires a traumatic event to be: (a) accurately encoded and stored, (b) blocked from awareness – owing to the traumatic event – and (c) accurately retrieved in pristine form. No case or study has been found replicating this.

Guidelines from the International Society for the Study of Trauma and Dissociation (2011) encourage therapists actively to search for 'alters' and evidence of sexual abuse using risky techniques, including hypnosis and abreaction. Treatment requires a minimum of 5 years and encourages extensive self-rumination. Typically, 'alters' proliferate alongside marked clinical deterioration in the form of florid post-traumatic stress disorder and '[h]allucinations, increasing discomfort, and severe dysphoria', often leading to 'states of chronic crisis for long periods of time' (Piper 2004). Other potential serious harm includes multiple suicide attempts, pseudo-memories of horrific ritual abuse and the fragmentation of family life.

DID in forensic settings

There are few reported cases of DID in the UK justice system. In *R v Baker* [2009], the defendant claimed one of his two alters, possessing a narcissistic quality, contributed to his fraudulent conduct. Expert evidence identified DID but concluded that he was capable of forming dishonest intent. In *R v Cowan* [2016], the defendant attributed the criminal act – sending distressing social media messages – to her 'alter ego'. Expert opinion concluded that she had an emotionally unstable personality disorder rather than DID. How the belief/diagnosis of DID emerged in the above cases is unknown.

The resurgence of DID has serious implications in other forensic contexts, notably:

(a) local authority care proceedings
(b) private law family proceedings, and
(c) criminal proceedings relating to childhood sexual abuse.

In category (a), a mother's DID rendered her unable safely to care for her child (*Re M (A Child: Care Order: Mother with Dissociative Identity Disorder)* [2015]). Her diagnosis arose during 2 years' treatment with an unspecified 'therapist'. Symptom presentation pretreatment is unknown. The court-accepted expert opined that the mother's DID was the product of severe recurrent childhood trauma, but was it? If the mother's condition was or may have been iatrogenically caused, this poses profound implications for public health and the integrity of the justice system. No category (b) or (c) case has been officially reported in the UK courts of which we are aware. However, a recent Australian case of a witness harbouring 2,500 alters (Moore 2019) who gave witness testimony against her abusive father (who pleaded guilty mid-trial), indicates similar cases may soon present within the UK criminal justice system. Evaluating the testimonial admissibility and if admitted in evidence, the reliability of disputed memories of childhood sexual abuse acquired during therapy will require expert evidence at trial and justice professionals' understanding of the relevant scientific and clinical issues, as well as full disclosure of the therapeutic modality and treatment records. The consequences of serious sexual allegations arising from genuinely held but potentially false or pseudo-memories of sexual abuse may lead to profound miscarriages of justice if they are not detected before trial.

Conclusions

That DID is experiencing a revival seems to us beyond doubt. Merskey's comment remains apposite: '[T]he simple, strong theory of repression of unpleasant material into the unconscious mind is no longer an acceptable version of what happens when people develop hysterical or dissociative symptoms' (Merskey 1998). We suggest that the Royal College of Psychiatrists publishes an updated version of its 1997 guidance document (Royal College of Psychiatrists 1997). We also suggest that professional training incorporates updated psychological and neurobiological research on human memory. The diagnosis and treatment of DID has important implications for public health and justice settings; we ignore DID at our peril.

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