BJPsych | The British Journal of Psychiatry (2022) 220, 98–100.

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

- The shadow costs of dissociative identity disorder
- Authors' reply
- Letter to the editor about 'Context and outcome of first-episode psychosis in India and Canada'
- Author's response

The shadow costs of dissociative identity disorder

The editorial entitled 'Dissociative identity disorder: out of the shadows at last?'[1] considers that the diagnosis has often been rejected through misleading information, and the prejudices derived therefrom, and through self-protection, a cultural dissociation from the reality of the impact of severe trauma on later clinical presentations. Psychiatrists can then choose to 'dislike' the diagnosis and refuse to use it in a way that would never happen, without severe medico-legal consequences, for schizophrenia or bipolar affective disorder. This occurs despite evidence that: many patients with dissociative identity disorder (DID) are severely ill and functionally impaired, have high rates of severe comorbidities, and are often at risk for non-suicidal self-injury and suicide attempts.[2] However, another reason for mental health services encouraging such dismissive perspectives, and stigmatising/scapegoating those who use the diagnosis, while denying those in need of treatment, is that the treatment is considered prohibitively expensive. Medication is of limited value[3] and specialist psychotherapy for DID not only takes years,[4] but recovery with therapy often has a non-linear course.[5] As psychiatric doctors define their domains by severe and enduring mental illness, with DID omitted, training of psychiatrists remains largely devoid of mention of complex trauma and its sequelae, with DID seen then as the province of others – such as clinical psychology.

DID is usually considered to be at the most severe end of a spectrum of complex trauma disorders, but its treatment requires different skills in the therapist from those required for treating someone with post-traumatic stress disorder (PTSD) not involving structural dissociation.[6] There are many ways to have a diagnosis of PTSD,[7] so the ICD-11 diagnosis of complex PTSD,[8] while welcome, will raise similar questions about the classification of individual patients with complex PTSD and DID, diagnoses which are not synonymous. Also, individuals with DID should not have diagnostic labels of non-dissociative or personality disorders, nor vaguely defined mood, anxiety or psychotic disorders, inappropriately attached to them; nor should clinicians feel the need to eschew the appropriate diagnosis of DID to avoid opprobrium, whether from other clinicians or from management. Any potential gains, service or financial, of not providing comprehensive, continuing, treatment that acknowledges causative factors are short term as there are long-term implications for morbidity and mortality, even across generations (see for example[9]). Pathological dissociation has an impact on the effectiveness, or otherwise, of specialist treatment for adults with histories of early traumatisation so its recognition is vital for treatment planning.[10] Moreover, a specialist online educational programme for patients and clinicians with dissociative disorders has been demonstrated to reduce non-suicidal self-injury in this group.[11] Clinicians should follow the evidence for DID; it has a defined aetiology and pathology, characteristic clinical features for which there are well-established structured interviews – and effective, non-pharmacological, treatments.

The development of the skills for treating DID can improve the ability to treat other disorders in which traumatic experiences have had an aetiological impact and that manifest with some expression of emotion dysregulation but, even with these additional gains, the comprehensive and effective treatment of DID will still have huge service implications. Training of staff to provide clinically relevant diagnostic formulations, and the appropriate treatments, could challenge individual ontological perspectives, and would require significant resources, but would benefit the many individuals who are burdened with the clinical manifestations of these severe post-traumatic states. There is also the distinct possibility that appropriate treatment would not be as economically burdensome as feared when the costs to society of hitherto-unrecognised disorders are compared with the costs to health services from the absence of appropriate treatment.[2]

Declaration of interest

None.

References

1 Reinders ATS, Veltman DJ. Dissociative identity disorder: out of the shadows at last? *Br J Psychiatry* 2020; https//doi.org/10.1192/bjp.2020.168.

2 Langeland W, Jepsen EKK, Brand BL, Kleven L, Loewenstein RJ, Putnam FW, et al. The economic burden of dissociative disorders: a qualitative systematic review of empirical studies. *Psychol Trauma* 2020; **12**: 730–8.

3 Ross CA. *Dissociative Identity Disorder: Diagnosis, Clinical Features, and Treatment of Multiple Personality*. John Wiley & Sons, 1997.

4 Brand BL, McNary SW, Myrick AC, Loewenstein RJ, Classen CC, Lanius RA, et al. A longitudinal, naturalistic study of dissociative disorder patients treated by community clinicians. *Psychol Trauma* 2013; **5**: 301–8.

5 Frewen P, Lanius RA. *Healing the Traumatized Self: Consciousness, Neuroscience, Treatment*. WW Norton, 2015.

6 Van der Hart O, Nijenhuis ERS, Steele K. *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization*. WW Norton, 2006.

7 Galatzer-Levy IR, Bryant RA. 636,120 Ways to have posttraumatic stress disorder. *Perspect Psychol Sci* 2013; **8**: 591–612.

8 Elklit A, Hyland P, Shevlin M. Evidence of symptom profiles consistent with posttraumatic stress disorder and complex posttraumatic stress disorder in different trauma samples. *Eur J Psychotraumatol* 2014, **5**: 24221.

9 Hesse E, Main M, Abrams KY, Rifkin A. Unresolved states regarding loss or abuse can have "second generation" effects: disorganization, role inversion, and frightening ideation in the offspring of traumatized, non-maltreating parents. In *Healing Trauma* (eds MF Solomon and DJ Sigel): 57–106. WW Norton, 2003.

10 Jepsen EKK, Langeland W, Heir T. Impact of dissociation and interpersonal functioning on inpatient treatment for early sexually abused adults. *Eur J Psychotraumatol* 2013; **4**: 22825.

11 Brand BL, Schielke HJ, Putnam KT, Putnam FW, Loewenstein RJ, Myrick A, et al. (2019) An online educational program for individuals with dissociative disorders and their clinicians: 1-year and 2-year follow-up. *J Traumatic Stress* 2019; **32**: 156–66.

Frank Corrigan, Trauma Psychotherapy Scotland, UK; **Alastair Hull**, NHS Tayside, UK. Email: fmcorrigan@aol.com

doi:10.1192/bjp.2021.73

Authors' reply

We welcome the opportunity to respond to Corrigan & Hull's response to our editorial[1] that presented neurobiological evidence for a trauma-related aetiology of dissociative identity disorder (DID). Corrigan & Hull offer an important additional reason to our proposed DID-dismissive perspectives, namely that DID

https://doi.org/10.1192/bjp.2021.73 Published online by Cambridge University Press