MORE FROM BACKSTAGE: A REJOINDER TO MERSKEY

Charles Barton, M.A., L.C.D.C.

Charles Barton, M.A., L.C.D.C., is a chemical dependency counselor in private practice in Dallas, Texas.

For reprints write Charles Barton, M.A., L.C.D.C., University of North Texas, 5024 Thunder Road, Dallas, TX 75255.

In "Backstage in Psychiatry," (Barton, 1994), I argued that Professor Merskey's (1992a) case lacked logical rigor and strong scientific proof. Merskey's response did not touch on most of the questions raised in "Backstage." Thus he appears uninterested in contesting these issues. In his reply Merskey continues to argue that Dissociative Identity Disorder (DID) has special traits which distinguish it from other mental disorders. I have shown that this argument fails when the alleged special qualities of DID are compared to those of other medical and psychiatric diagnoses. In no instance are the alleged special attributes unique to DID.

Several of Merskey's contentions deserve response, because they represent issues not covered in "Backstage." First, Professor Merskey points to the increase in the number of cases diagnosed with Dissociative Identity Disorder during the last twenty years as a matter for concern. But the *DSM-III* era was characterized by drastic increases in the number of reported cases for several diagnostic categories. Do increases or decreases in the number of reported case of a mental disorder over time really indicate anything about the validity of the diagnosis? *DSM-III* reported that Obsessive-Compulsive Disorder was rare. Now *DSM-IV* reports an prevalence rate for Obsessive-Compulsive Disorder of from 1.5% to 2.1% of the general population. Is there grounds for concern that this explosion of cases has been produced by misguided therapists and culturally-directed clients? If not, how does this "epidemic" of Obsessive-Compulsive cases differ from the increase of DID cases?

Secondly, Merskey again asserts that the idea of DID causes all manifestations of this disorder. He argued that the idea of DID arose when historical cases involving rapidly cycling bipolar disorder were mistakenly diagnosed as suffering from a divided consciousness. Merskey (1992b), for example, has argued that Anna O. had a depressive illness. But this contention has been contradicted by Loewenstein's (1993) careful analysis of Bertha Pappenheim's (Anna O's) symptoms. Loewenstein found striking similarities between Pappenheim's symptoms and those of recent MPD cases. My own analysis of the Pappenheim case (Barton, 1993) confirmed Loewenstein's results and demonstrated that in a number of instances, Merskey's assertions are contradicted by primary sources. He claims, for example, that Pappenheim's "absences" were nothing more "than depressive hesitations such as stopping in speech" (Merskey, 1992b, p. 190). This explanation contradicts Pappenheim's own written report of "time missing" during the absences, and her statement that others had told her that she talked vivaciously during the absences (Hirschmuller 1989). In other instances, Merskey's drew historical inferences that were unsupported by evidence he cited. For example, he claimed that Pappenheim's symptoms were characteristic of her cultural environment. In fact, symptoms such as Pappenheim's loss of her ability to speak German had no 19th century parallels in Austrian society. Space prevents reporting more such problems.

Thirdly, Merskey claims that DID diagnostic procedures are culturally scripted enactments. But Kleinman (1980) has postulated, in effect, that all transactions between patients and healers are culturally scripted. Kleinman and Kleinman (1985) show that symptom presentation of mental disorders is culturally variable, and that mental disorders such as depression may have strikingly different symptoms in non-western societies. Obeyesekere (1985) has argued that psychopathology is a culture-based interpretation; i.e., that behaviors and attitudes which American's mental health professionals regard as manifestations of clinical depression may be regarded as evidence of good mental health in Sri Lanka. Thus, it is not enough to argue that patient-therapists transactions in DID are culturally scripted. It must also be shown that a significant different exists between the cultural scripting of DID and other mental disorders. This, I contend, is what Merskey has failed to demonstrate.

Finally, there is the matter of science. Rather than criticizing research designs and methodologies, Merskey dismissed scientific literature supporting the DID diagnosis as "not impressive," and "not carrying conviction." He appears to have preclude the very possibility of an empirical validation for the proposition that DID exists as a "spontaneous phenomena." Attempts to validate diagnostic instruments prove only that "the examiner and patient do the same thing." By Popper's (1968) standards, theories must be falsifiable to be scientific. If science requires empirical tests of propositions, Merskey can offer us none, because, he argues, no empirical test is credible. In so doing, he also has excluded the possibility of scientifically grounding his own views. Merskey's beliefs do not constitute a scientific theory, because they cannot be falsified. ■

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