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Re: Meeting Dr Jekyll

Dear Sir,

Thanks to Suetani and Markwick for publishing their case report (AP October 2014). In the deeply contested field of Dissociated Identity Disorder (DID), case studies offer readers the opportunity to develop their views on this topic. The authors rightly point out that the history of this condition is beset by controversy – but come close to a significant error by stating that Sybil (aka Shirley Ardell Mason) may have been an iatrogenic case (citing Rieber).1

The truth is much more than that and has a great influence on public perception, as well as scientific acceptance of the disorder. Shirley Mason, the Sybil of the book and movie, told David Spiegel in 1968 that she had faked her symptoms to please her therapist, Cornelia Wilbur.2 Any lingering doubts about the matter were blown out of the water by the publication of Sybil Exposed, which revealed the extraordinary extent of the deception by the psychiatrist, patient and journalist who collaborated on the book.3 Wilbur’s treatment of her patient was a gross caricature of therapy, with Mason turned into a mendicant drug addict, ending up living with her in a semi-servant role. Wilbur, who thought she deserved a Nobel Prize, lobbied ceaselessly and successfully for the inclusion of DID into DSM-111.

This matters. As Harold Merskey and other writers have pointed out, there were less than 100 reports of DID in the previous century.4 After Sybil, there was an exponential growth in cases, as well as the number of alters – a classic case of bracket creep (to quote Richard McNally). As the perturbations of DSM show, diagnosis is heavily influenced by social factors. That a gross falsification like Sybil could have such a large influence illustrates the dangers of conducting an ahistorical psychiatric science, if not the continuing hazard of psychiatric fads.5 As for Wilbur and co., one can only cite Merskey’s epilogue on the whole phenomenon: When the intellectual faculties are only slightly loosened, there is no end to the developments that will occur.


It was with mixed emotions that we read Large and Ryan’s opinion piece regarding suicide risk categorisation.1 We certainly agree with the notion that risk assessment, for both violence and self-harm, should not focus purely on risk categorisation. As we discussed in a recent article,2 simply allocating patients to a category of low, medium or high risk, within the complexity of real-world risk management decisions, is insufficient. As Large and Ryan rightly conclude,1 “None of this is to imply that clinical features often regarded as suicide risk factors – suicidal ideation, depression, substance use, hopelessness etc. – should be ignored. The identification and mitigation of these factors makes sense and can be expected to prevent some suicides”. This is the underlying principle of risk assessment and management in mental health, and an integral part of patient care.

Our concern lies with Large and Ryan’s erroneous representation of the enthrustable professional activity (EPA).3 We have been involved in the process of developing this EPA, and are aware of the content and from where it derives. The full title of the Risk Assessment EPA is ‘Assessment and management of risk of harm to self and others’. Nowhere is it referred to as the “risk categorisation EPA”, as incorrectly submitted by Large and Ryan.1 The only reference to the concept of ‘risk categorisation’ is in the required attitudes section, where it is warned against, “Adherence to framework that conceives risk assessment as managing identified risk by meeting relevant clinical needs, not simply providing a predictive categorical label”.3

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References
with Large and Ryan’s position. Hence our surprise that they believe it “should be removed”!1

We hope that psychiatry trainees and their supervisors are not misled by Large and Ryan’s discussion, and we encourage all trainees and supervisors to read the EPA for themselves.

References


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Answers to self-assessment (from p. 80):

1. B
2. i) I
   ii) A
   iii) A
3. i) C
   ii) B
   iii) E.