ELSEVIER

Journal of Affective Disorders 58 (2000) 155–159

JOURNAL OF AFFECTIVE DISORDERS

www.elsevier.com/locate/jad

Brief report

A note on suicidal deterioration with recovered memory treatment

Janet Fetkewicz[a], Verinder Sharma[b], Harold Merskey[c,*]

[a]False Memory Syndrome Foundation, 3401 Market Street, Suite 130, Philadelphia, PA 19104-3315, USA
[b]Mood Disorders Unit, London Psychiatric Hospital, 850 Highbury Avenue, P.O. Box 2532, London, ON, Canada N6A 4H1
[c]Department of Psychiatry, London Health Sciences Centre, University Campus, 339 Windermere Road, London, ON, Canada N6A 5A5

Received 1 April 1998; accepted 22 September 1998

Abstract

Background: Many patients who have been told they have Multiple Personality/Dissociative Identity Disorder (MPD/DID) seem to have deteriorated clinically after being so diagnosed. We report here the results of a survey of suicide attempts in patients diagnosed as having MPD and a comparison group hospitalized with a mood disorder. *Methods*: Twenty individuals who had been diagnosed as having MPD, had developed false memories, and had relinquished them, were surveyed with respect to suicide attempts before and after the diagnosis. Twelve of those approached agreed to provide data and were compared with 12 patients from an in-patient mood disorders unit, matched for age and sex. *Results*: In the MPD group more patients attempted suicide after being diagnosed than before and they made more separate attempts at suicide than before. The reverse was true in the comparison group with patients and suicide attempts before and after hospitalization. Comparing the numbers of attempts in the groups before diagnosis/hospitalization and afterward $Chi^2 = 20.177$, $DF = 1$, $P < 0.001$. *Limitations and Conclusions*: Both samples were highly selected, and the comparison group does not provide an exact control. Nevertheless, the results support a trend in the literature that finds the diagnosis of multiple personality disorder and the use of recovered memory treatment are harmful. © 2000 Elsevier Science B.V. All rights reserved.

Keywords: Attempted suicide; Recovered memory; False memory; Multiple personality disorder; Dissociative identity disorder

Recovered memory therapy (RMT) is a highly controversial procedure which has given rise to Position Statements by at least seven professional bodies of which four have expressed strong reservations about the validity of recovered memory (RM) (American Medical Association, 1994; Australian Psychological Association, 1994; Canadian Psychiatric Association, 1996; Royal College of Psychiatrists, 1977), while the remainder have been variously sympathetic (British Psychological Society, 1995), wary (American Psychiatric Association, 1993) or bitterly divided (American Psychological Association, 1994). McElroy and Keck (1995) described three patients who were treated first by recovered memory therapy with poor results, and later by conventional psychiatric methods with good results. Lief and Fetkewicz (1995) in a group of 40 individuals who had retracted false memories noted that, in the process of developing pseudomemories,

*Corresponding author. Tel.: + 1-519-663-3515; fax: + 1-519-663-3935

0165-0327/00/$ – see front matter © 2000 Elsevier Science B.V. All rights reserved.
PII: S0165-0327(98)00193-1

the patients had felt more worthless, hopeless and suicidal than before.

One of us (HM), has seen in consultation or treatment, six such cases with a combination of troublesome recovered memories and DID/MPD, as well as two false memory cases without MPD, and noted substantial deterioration with recovered memory treatment. Striking accounts of deterioration with recovered memory treatment have also been given in a number of books which criticized its use (Goldstein and Farmer, 1992; Pendergrast, 1995; Ofshe and Watters, 1994; Loftus, 1996). Loftus (1996) presented data on a review of a random sample of 183 approved claims based on repressed memory made to the Washington State Crime Victims Compensation program. Of 183 claims selected from 325 approved claims, 30 were randomly selected for closer examination. In this group, only three claimants thought about suicide, or attempted suicide, before recovering their first memory, but 20 did so after recovering memories. Two had been hospitalized prior to their first memory, while 11 were hospitalized after memories started. One person engaged in self-mutilation before memories, and eight did so afterwards. Twenty-two patients claimed memories of cannibalism of new-born babies and infants conducted under circumstances of Satantic ritual abuse.

Loftus gives much other information on features of deterioration, as do other references cited here (Lief and Fetkewicz, 1995; Goldstein and Farmer, 1992; Pendergrast, 1995; Ofshe and Watters, 1994). Deterioration appears to occur to a very marked extent in patients with MPD/DID, combined with false memories. Its occurrence is expected by those who seek for recovered memories. For example, Bass and Davis (1992) who have been most influential in the spread of false memories through their book, The Courage to Heal (which within its first five or six years had sold 750 000 copies and continues to be widely available), observed that when 'clients' recover their 'memories', there is often a stage of acute difficulty. They call this the emergency stage and observe that patients find themselves 'having flash-backs' uncontrollably, crying all day long or unable to go to work. They offer advice on how to avoid suicidal or self-destructive actions in these circumstances, as well as other modes of coping (emphasizing the importance of the therapist as a life-line). The deterioration appears to be very marked in patients with MPD/DID combined with false memories. Striking examples are provided by Pendergrast (1995); Ofshe and Watters (1994).

We report here the results of a survey in twelve individuals who had developed MPD plus false memories which they relinquished with benefit. It was hoped in this survey to obtain information specifically about the frequency of suicidal ideation and suicidal acts in individuals who had experienced recovered memory treatment, recovered from it and rejected their prior apparent false beliefs. These twelve individuals have been compared with another twelve matched for age and sex who were admitted to hospital for the treatment of intractable depressive illness without a diagnosis of multiple personality disorder.

1. Subjects and method

Twenty individuals who had received the diagnosis of MPD and had been hospitalized for it, were randomly selected from the FMSF data base. Following treatment these individuals had recovered memories which they retracted later on. Of these 20, 12 agreed to participate in the study. Three were unable to participate due to litigation; two could not be reached; two refused and one individual disclosed that the diagnosis of MPD was not formal. Subjects were asked about the initial reason for seeking help, suicidal ideation and suicide attempts. Of those reporting a history of suicide attempts, detailed information including a description of circumstances under which the attempt was made, location, timing of suicide attempts in relation to the diagnosis of MPD, method used and seriousness of the attempt was obtained.

Twelve comparison patients, matched for age and sex with the index group, were selected randomly from a group of patients admitted between 1991 and 1996 to a specialized mood disorders unit in a provincial psychiatric hospital and had received at least one year of follow-up care.

2. Results

Twelve MPD subjects (11 females and 1 male) with a mean age of 36.2 years (SD = 9.7, range, 24 to 56 years) participated in the study. All of the patients had graduated from high school and ten had post high school education. Nine were currently married, two were single and one was divorced. The comparison group comprised 11 females and one male (mean age of 36.7, range 24 to 56 years). All of the control group had graduated from high school and five were currently married, one was divorced and six were single.

In the MPD group six respondents listed 'depression' among their reasons for seeking help. Four of these listed depression as the only reason. Additional answers included relationship problems (parenting and marital/intimacy issues) (five), physical problems (one), codependency issues (one), nightmares from a car accident (one), incest in childhood (one), and eating disorders as a teen (one). Two patients in the comparison group received the diagnosis of major depression, four had bipolar-I disorder and six patients suffered from bipolar-II disorder. The course of the illness was punctuated with repeated mixed episodes in five patients in the bipolar group.

The two groups were compared with respect to the number of individuals making suicidal attempts and the number of attempts (Table 1). Seven of the 12 index patients had attempted suicide. One had made nine attempts prior to receiving the diagnosis of MPD. One made attempts both before and after the diagnosis and five attempted suicide only after the diagnosis of MPD. Half of the suicide attempts before and nearly 80% after the diagnosis of MPD involved drug overdoses including antidepressants. Two of the five who only attempted suicide after the MPD diagnosis indicated that they had never thought seriously about suicide before this diagnosis, but three had. In total 27 suicide attempts were made; 11 before the diagnosis of MPD and 16 afterwards. Six patients who attempted suicide after the diagnosis of MPD was made, indicated that receiving this diagnosis and therapy for recovered memories played a role in the suicide attempt. In the index group the premorbid attempts included drug overdoses and in the patient who made the most attempts, frequent wrist slashing with suicidal intent. The majority of the MPD patients described very serious attempts including several with overdoses requiring resuscitation by respirator and in two instances, the use of gas (carbon monoxide or domestic gas).

Among the controls two patients made no suicide attempts and four made one attempt before hospitalization but none afterward. The remaining six made a total of ninety-nine attempts before hospitalization and sixteen attempts afterwards. Comparing the numbers by group (MPD diagnosis or control) and phase (before or after the diagnosis of MPD or hospitalization) $\text{Chi}^2 = 20.177$, $DF = 1$, $P < 0.001$.

The duration of the episodes of illness before and after the diagnosis of MPD or hospitalization in the two groups is rather similar. Thus the range of follow-up for the index group was two to five years, while for the mood disorder group it was one to four years. This difference favours the mood disorders group since it allows a little less time in which suicide attempts might have occurred.

Within the MPD group the period of treatment before diagnosis ranged from eighteen months to two

Table 1
Number of suicide attempts in 12 patients with a diagnosis of multiple personality disorder and 12 others with mood disorders

	Number of suicide attempts	
	MPD Group	Mood disorders group
Before diagnosis or hospitalization	11(2)	103(10)
After diagnosis or hospitalization	16(6)	16(6)
Totals	27(7)[a]	119(10)[b]

() = number of individuals.
[a] One patient made attempts before and afterwards.
[b] Six patients made attempts before and afterwards.
Chi^2 for frequency = 20.177, $DF = 1$, $P < 0.001$.

years for those who made suicide attempts, and from six months to two years for those who did not make suicide attempts (based on a total of 11 patients for whom data on duration was available). Likewise the range for those followed after discharge was between 27 months to 5 years for those who had made suicide attempts during the phase of being diagnosed as having MPD, while it was 28 months to 4 years for those who did not make suicide attempts.

3. Discussion

At least half of the respondents were depressed and for one third of the respondents this was the only reason for seeking help. Many studies have found that patients with major depression are at a significantly higher risk than the general population, both for suicide and parasuicide (Tanney, 1992). It can be argued that an apparent increased likelihood of suicide attempts following the diagnosis of MPD, was due to a failure to identify and treat depression. This could have played a role but the majority of the respondents (six out of seven) referred specifically to the MPD diagnosis, to false memories or to questionable therapy as having contributed to the suicide attempts. For example, one respondent commented, "it is awful to be diagnosed MPD" as having contributed to the suicide attempts. Another said "I just couldn't accept my diagnosis, or the thought that my family was abusing me". A third respondent pointed to the damaging effect of therapy and its contribution to her feelings of hopelessness and despair. Some of the respondents had been told that the suicide attempts were a result of MPD.

Clearly, the subjects interviewed had many more months of life before the MPD diagnosis was made, than afterwards. Such figures cannot well be used to test the view that the diagnosis of MPD/DID may be harmful since the length of the relevant period of illness prior to the MPD diagnosis is uncertain compared with the period following the point in time when that diagnosis was accepted by the patients. Thus, comparing the length of such phases as before and after could prove enlightening but we lack firm data on the topic. Nevertheless five significantly suicidal patients out of 12 after a short period of treatment (compared with one before) generates an objection to promoting the concept of recovered memories with MPD.

Whereas patients diagnosed with MPD appeared to deteriorate once they had been given their diagnosis, patients with mood disorders unquestionably improved and maintained a significant degree of improvement with conventional psychiatric treatment, relying heavily upon pharmacology and social management. This comparison group cannot be guaranteed as an exact control for the MPD patients but shows that much benefit can occur in normal practice with depressed individuals before and after certain types of treatment, benefits which were much less apparent in the MPD group once the diagnosis of MPD had been made. This is particularly so when compared with the results of conventional treatment for mood disorders from which many MPD patients are believed to suffer.

The majority of the MPD respondents believed their life was at risk when they attempted suicide and said that they intended to die. Indeed, some of the suicide attempts were quite serious due to the nature of the method used (Sakinofsky et al., 1990). Parasuicide (non-lethal suicidal behaviour) is an important risk factor for suicide. Long-term follow-up studies have shown that 10 to 13% of patients who make suicide attempts, eventually kill themselves. Depression is a highly treatable illness, however, and early detection and appropriate treatment are the key elements. Not only were the MPD respondents in this study misdiagnosed and mismanaged but, also, the failure to diagnose and treat depression contributed to their distress and feelings of guilt.

References

American Medical Association, 1994. Report of the Council on Scientific Affairs: Memories of Childhood Abuse. CSA Report 5-A-94.

American Psychiatric Association, 1993. Statement approved by the Board of Trustees, December 12, 1993. American Psychiatric Association, Washington, DC.

American Psychological Association, 1994. Interim Report of the APA Working Group on Investigation of Memories of Childhood Abuse. American Psychological Association, Washington, D.C.

Australian Psychological Association, 1994. Guidelines Relating

to the Reporting of Recovered Memories. Australian Psychological Association, Sydney, NSW.

Bass, E., Davis, L., 1992. The Courage to Heal: The Guide for Women Survivors of Child Sexual Abuse. Harper, Collins Publishers Incorporated, New York, NY, 1988, second ed. 1992.

British Psychological Society, 1995. Recovered Memories: The Report of the Working Party of the British Psychological Society.

Canadian Psychiatric Association, 1996. Position statement on adult recovered memories of childhood sexual abuse. Can. J. Psychiatr. 42, 305–306.

Goldstein, E., Farmer, K., 1992. Confabulations: Creating False Memories, Destroying Families. SIRS, Boca Raton, FL.

Lief, H.I., Fetkewicz, J., 1995. Retractors of false memories: The evolution of pseudomemories. J. Psychiatr. Law 23, 411–435.

Loftus, E., 1996. Data presented at the Southwestern Psychological Association Meeting, Houston, TX, April 5, 1996. Summarized in False Memory Syndrome Foundation Newsletter, May 1, 1996, p. 1.

McElroy, S.L., Keck, P.E., 1995. Misattribution of eating and obsessive–compulsive disorder symptoms to repressed memories and childhood sexual or physical abuse. Biol. Psychiatr. 37, 48–51.

Ofshe, R., Watters, E., 1994. Making Monsters: False Memories, Psychotherapy and Sexual Hysteria. Charles Scribner's Sons, New York, NY.

Pendergrast, M., 1995. Victims of Memory. Incest Accusations and Shattered Lives. Upper Access Books, Hinesburg, VT.

Royal College of Psychiatrists, 1977. Reported recovered memories of child sexual abuse. Psychiatr. Bull. 21, 663–665.

Sakinofsky, I., Roberts, R.S., Brown, Y., Cumming, D., James, P., 1990. Problem resolution and repetition of parasuicide: A prospective study. Brit. J. Psychiatr. 156, 395–399.

Tanney, B.L., 1992. Mental disorders, psychiatric patients and suicide. In: Maris, R., Berman, A., Maltsberger, J., Yufit, R. (Eds). Assessment and Prediction of Suicide. Guilford Press, New York, NY, pp. 277–320.