Dissociative disorders have been recognised in both DSM-IV and ICD-10 for some 25 years now. Yet among psychiatrists in particular, they continue to be denied or misdiagnosed, causing serious re-traumatisation for a significant number of patients.

Merskey writes of the absence of 'critical statement[s] by a professional society', but fails to cite the acknowledged leaders in the field, the International Society for the Study of Trauma and Dissociation (ISSTD; www.isst-d.org) and the European Society for Trauma and Dissociation (ESTD; www.estd.org). The ISSTD includes among its members a number of eminent psychiatrists and psychologists and it has produced extensive online guidelines on treatment. The charity First Person Plural, in association with the ESTD and Cheshire & Wirral Partnership NHS Foundation Trust, has produced a training and information DVD.[2]

Furthermore, the National Institute for Health and Clinical Excellence's guidelines accept the existence of dissociative disorders. It has not yet produced a treatment protocol for this condition and recommends that clinicians follow the guidelines of the best informed organisation (www.isst-d.org/education/treatmentguidelines-index.htm).

It should be noted that many psychiatric services and community mental health teams across the country are now implementing treatment protocols for dissociative identity disorder and dissociative disorders that are not only effecting significant changes for patients but are also bringing about cost savings for services.[3]

Declaration of interest

R.A. is President of the European Society for Trauma and Dissociation.

1 Mersky H. Book review: *Attachment, Trauma and Multiplicity: Working with Dissociative Identity Disorder*. *Br J Psychiatry* 2011; **199**: 347–8.

2 First Person Plural. *A Logical Way of Being: The Reality of Dissociative Identity Disorder and Other Complex Dissociative Conditions* (DVD). FPP (http://www.firstpersonplural.org.uk).

3 Lloyd M. How investing in therapeutic services provides a clinical cost saving in the long term. *Health Serv J* 2011; 1 Sept.

Remy Aquarone, European Society for Trauma and Dissociation. Email: remyaquarone@btconnect.com

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Author's reply: Dissociation begins with hypnotists, was developed by Janet, promoted by Freud and ruined by the absurdities of multiple personality disorder.[1] Consider Janet[2] hypnotising 'Lucie', an alternative personality of this patient producing automatic writing:

Q. 'How are you?'
A. 'I don't know.'
Q. 'There must be someone there who hears me.'
A. 'Yes.'
Q. 'Who is it?'
A. 'Someone other than Lucie.'
Q. 'Ah, Indeed!'
A. 'Another person.'
Q. 'Would you like us to give her a name?'
A. 'No.'
Q. 'Yes it will be more convenient.'
A. 'Alright, Adrienne.'
Q. 'Very well Adrienne. Do you hear me?'
A. 'Yes.'

In 1889 Binet observed that Janet '. . . himself created her by suggestion'.[3]

Hacking[4] showed that the first 19th-century fugue states in young men were in French military conscripts exploiting the novel long-distance continental railways. In older persons fugues are only found with dementia. Experimental attempts by excellent social psychologists over 60 years have completely failed to replicate repression[5] and dissociation. Freud's own accounts of his cases with alleged repression/dissociation were completely unreliable,[6] particularly as shown in the Freud–Fliess correspondence.[7] Further, Pope *et al*[8] have shown that a phenomenon like dissociation (i.e. losing complete trace of some important event and then recovering it through memory) has not been found so far in world literature preceding 1786, and by then Mesmer was actively using hypnotic procedures. If dissociation is a genuine human experience, it is remarkable that it was not known before that time.

There is no case of proven 'dissociation' fulfilling Pope's criteria without organic disorder, although many cases of alleged dissociative memory loss exist, not to mention the generally rejected syndrome of dissociative identity disorder, of which dissociation is the artefactual foundation no matter how much the name or term may be changed.

1 Merskey H. The manufacture of personalities: the production of multiple personality disorder. *Br J Psychiatry* 1992; **160**: 327–40.

2 Janet P. *L'Automatisme psychologique*. Felix Alcan, 1889.

3 Binet A. *Les altérations de la personnalité*. Felix Alcan, 1892. Reprinted as *Alterations of Personality* (ed DN Robinson). Georgetown University Publciations of America, 1977: 146.

4 Hacking I. *Mad Travelers. Reflections on the Reality of Transient Mental Illnesses*. University of Virginia, 1998.

5 Holmes DS. The evidence for repression: an examination of 60 years of research. In *Repression and Dissociation. Implications for Personality Theory, Psychopathology, and Health* (ed JL Singer). University of Chicago Press, 1990: 85–102.

6 Grunbaum A. Made-to-order evidence. *Unauthorized Freud: Doubters Confront a Legend* (ed FC Crews). Viking, 1998: 76–84.

7 Masson JM (trans & ed). *The Complete Letters of Sigmund Freud to Wilhelm Fliess, 1887–1904*. Belknap Press, 1986.

8 Pope Jr HG, Poliakoff MB, Parker MP, Boynes M, Hudson JI. Is dissociative amnesia a culture bound syndrome? Findings from a survey of historical literature. *Psychol Med* 2007; **37**: 225–33.

Harold Merskey, Professor Emeritus of Psychiatry, 71 Logan Avenue, London, Ontario N5Y 2PG, Canada. Email: harold.merskey@sympatico.ca

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Childhood sexual abuse and chronic fatigue syndrome

We have read the important article on the premorbid risk markers for chronic fatigue syndrome in the 1958 British birth cohort[1] with a lot of interest. The authors reported that parental physical abuse, childhood gastrointestinal symptoms and parental reports of many colds were independently associated with self-reported chronic fatigue syndrome (CFS), after adjusting for psychopathology.

Notably, the authors did not comment on the fact that parental physical abuse, but not sexual abuse, was predictive of CFS, even though childhood sexual abuse is a well-documented risk factor for CFS. More precisely, chronic fatigue was significantly predicted by childhood sexual abuse in a population-based study by Taylor & Jason.[2] Also, childhood sexual abuse and emotional abuse were most effective in discriminating CFS cases from control individuals in two population-based studies by Heim *et al* (as well as emotional neglect in one of these studies).[3,4] A possible reason for this inconsistency is the relatively low frequency of sexual abuse in the study by Clark *et al*[1] (6.3 %), compared with its frequency in the others studies (>26%).[2–4]

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