Review Paper

The Persistence of Folly: Critical Examination of Dissociative Identity Disorder. Part II. The Defence and Decline of Multiple Personality or Dissociative Identity Disorder

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In this second part of our review, we continue to explore the illogical nature of the arguments offered to support the concept of dissociative identity disorder (DID). We also examine the harm done to patients by DID proponents' diagnostic and treatment methods. It is shown that these practices reify the alters and thereby iatrogenically encourage patients to behave as if they have multiple selves. We next examine the factors that make impossible a reliable diagnosis of DID—for example, the unsatisfactory, vague, and elastic definition of "alter personality." Because the diagnosis is unreliable, we believe that US and Canadian courts cannot responsibly accept testimony in favour of DID. Finally, we conclude with a guess about the condition's status over the next 10 years.

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Highlights

- The arguments offered to support the concept of dissociative identity disorder (DID) are illogical.
- DID proponents' diagnostic and treatment methods iatrogenically encourage patients to behave as if they have multiple selves.
- The unsatisfactory, vague, and elastic definition of "alter personality" makes a reliable diagnosis of DID impossible.

Key Words: *iatrogenesis, childhood trauma, multiple personality disorder, dissociative identity disorder*

A Straw Man Argument About Suggestion in Therapy

The diagnoses of multiple personality disorder (MPD) or dissociative identity disorder (DID) have generated fantastic claims and a series of complacent but improbable defences. We here examine some of the latter.

DID proponents sometimes claim that their diagnostic and treatment practices represent nothing more than clinical inquiries. Thus those who raise concerns about these practices are asked such questions as these, posed by Putnam:

> Why should suggestion effects be unique to MPD? We do not believe that asking about hallucinations produces them in a patient. Why should asking about the existence of 'other parts' of the self produce alter personalities? What is so magical about this question? (1, p 960)

However, the concerns arise not from proponents' mere inquiries about "other parts"—suggestive though these inquiries may be—but rather from interventions that are considerably more muscular. Consider, for instance, Kluft's description of his therapy with alter personalities:

> I rarely let a session go by without accessing several alters. . . . I will assign pairs or groups of alters the task of talking together about decisions to be made or issues of concern, but [at the beginning of treatment] I want them to do no more than spend time together and hold casual conversations. I will ask alters to comment on what is happening in therapy, and invite their participation. . . . If an alter is represented as

> pre-verbal, non-human, able to speak [only] in another language, or otherwise incapacitated, I will find an alter that can communicate with it, and be its translator. Some alters are constructed without a voice or mouth in order to be unable to make revelations and (or) to preclude oral traumata. . . . I ask if there are any alters who want to die, commit suicide, or inflict injury to others in the system. I immediately try to get them into a dialog with me and to either contract for safety or to suspend their activity, perhaps by going to sleep between appointments. . . . If they threaten or menace me, I suggest that they communicate with me through another alter (2, p 155).

Kluft also "[assigns] alters problems to resolve and issues to discuss, [intending to increase] mutual empathy, identification, and understanding." He continues, "I recommend [that] 15 to 30 minutes per day be spent in this manner" (2, p 156).

Similar examples abound in the DID literature (3–5). Dell and Eisenhower talk to each guest personality to secure its commitment to the patient's therapy and explictly introduce the alters to the patient's family (6). Ross invites alters to help decide whether the patient should enter therapy (7) and allows them to work on age-appropriate children's projects in occupational therapy ("to show respect for the alter"; 8, p 46). Fine enlisted a personality ("Pandora") as a cotherapist "to help oversee the sharing of the feelings among [the patient's] child personalities" (9, p 149). Bliss summons personalities and asks them "to speak freely. . . . When they appear, the [patient] is asked to listen [and] is then introduced to some of the personalities" (10, p 1393). A standard reference recommends interpretive work with personalities to help "one alternate understand the emotional conflicts of [other alters]" (11, p 2212). Finally, his above-quoted comments about suggestion notwithstanding, Putnam himself recommends occasionally letting child alters "out" so that adult alters can provide "nurturant experiences" for them, as well as teaching adult personalities to "hold" a child personality while it recounts or reexperiences a painful memory (12, p 193).

One cannot reasonably doubt that such interventions lie some distance beyond merely asking about "other parts," and that their suggestive nature is likely to both encourage and reinforce displays of multiplicity. Moreover, the interventions clearly contradict the DID literature's frequent assertions that its practitioners do not interact with alternate personalities "as if they were different people" (13, p 48) and do not "encourage patients to construe themselves as having multiple selves" (13, p 47).

Reliability of the DID Diagnosis: Daubert Concerns

We next examine another defence that proponents offer: DID can be accurately diagnosed (14–17).

According to Kluft, DID's signs are often evanescent (18); therefore, most patients will satisfy DID diagnostic criteria at some times but not at others. Many cases may thus be diagnosable only intermittently (19). The disorder's signs can also be extremely subtle. Only 20% of DID patients exhibit clear manifestations of the condition at initial evaluation (20); 40% are "very highly disguised indeed . . . [and offer] no strong suggestive signs" of MPD (21, p 620). In one study, 40% of those eventually diagnosed with MPD showed no overt signs whatsoever on initial evaluation (22).

Moreover, Braun says that DID patients "may actively resist diagnosis by withholding information or lying, or may [deliberately misdirect] the therapist" (23). According to the DID literature, patients frequently hide their difficulties from clinicians, even those they have known for years, and they usually deny having dissociative symptoms. Further, they often have secrets from themselves, because dissociation supposedly erases patients' memories of their own trauma histories—and even of any knowledge that they have indwelling alters (24–27).

Before patients enter therapy, even close relatives usually do not see overt manifestations of multiple identities (28,29). In one study, relatives had to be introduced to the alters, because these guest personalities had not been evident before (6). The leading DID proponents make no mention of seeing overt signs of alters at the beginning of treatment, even in those people who eventually receive a DID diagnosis (6,25,30,31). Indeed, Ross says that someone who initially presented speaking of "us" or "we" would be suspected of malingering (32, p 106).

Lax diagnostic criteria plague DID. Although the criteria have undergone minor changes from one edition to another of the DSM, all editions have required that control of the patient be intermittently taken over by one or more "identities," "personalities," or "personality states." However, anyone searching the DSM for a definition of "identity" or "personality state" will search in vain, will find no guidance on how significant the behaviour change must be to qualify as being induced by an identity, and will discover that the manual provides no exclusionary criteria for the disorder. Further, the DSM is silent on several other questions (19,31,33): What does "take control" mean? How does one recognize that such transfer of control has occurred? How can a "personality state" be differentiated from the transient emotions everyone experiences? Finally, because the DSMs fail to specify the limits of the "personality" concept, even an entity that appears "only once, for a single mission" in a person's entire life can qualify as an alter personality (34, p 136).

These lax and vague DSM diagnostic criteria allow the concept of an alter personality to be defined in virtually any way imaginable. Proponents thus claim that specialized alters perform all kinds of tasks, such as doing schoolwork, selling illicit drugs, dancing in strip clubs, cleaning bathtubs (12,32,35) or "dealing with in-laws, holidays, weddings, and funerals" (36, p 8). Bliss describes one personality whose job was to "gaily [walk] in the fields picking flowers—usually dandelions"; another handled sex with her host's husband (34, p 146). In an accused embezzler's trial, a professor of psychiatry from one US university testified that the defendant's alters, not the host, had taken the money (the defendant was nevertheless promptly convicted) (37). If one believes that

behaviours such as these reveal hidden alters, it becomes easy to see how diagnosed DID cases could have increased so dramatically in the 1980s.

In addition to vagueness, the DID diagnosis is also plagued by concerns about malingering. Several frankly malingered cases have been published; it is well known that behaviour characteristic of alter personalities can quite easily be role-played (38–41). This ease of role-playing is particularly worrisome, given that 3 proponents of the posttraumatic model discovered that not even they could distinguish actual from malingered MPD (42,43). If practitioners who have studied dissociative disorders for years cannot reliably make this distinction, it would seem that other clinicians are unlikely to do so.

Further, proponents claim that, at any time, the DID patient's clinical picture can be dominated by any psychiatric or medical symptom or sign (17,18,44,45). Moreover, any medical symptom or sign may be present in only one alter, and not in another, or in one alter at only some times and not others (44).

Finally, in the dissociative disorder literature, conditions that resemble DID are often simply redefined as DID. Thus, Putnam asserts that "although a substantial percentage of MPD patients are diagnosed as having a bipolar disorder, in most cases the superordinate diagnosis is actually MPD" (12, p 257). Similarly, Kluft claims that "many people considered [to be] untreatable psychotics proved to be treatable multiples" (46, p 235).

We believe the foregoing discussion should make it apparent that DID—with manifestations that are visible to only some clinicians and on only some occasions; with symptoms that cannot be distinguished from other psychiatric disorders or from malingering; with unacceptably vague diagnostic criteria; and with patients who initially deny their symptoms, show no signs of the condition's essential feature, and know nothing of either their traumatic histories or the presence of alters—simply cannot be reliably diagnosed.

Reliability weighs heavily in decisions about whether scientific testimony will be admitted into legal proceedings. In the case of Daubert v Merrell Dow Pharmaceuticals (47), the US Supreme Court articulated several guidelines intended to help such decisions. One guideline asks whether the testimony helps the judge or jury to understand a disputed fact: an unreliable diagnosis will not perform this task. Another guideline requires an acceptable potential error rate for any evidence: DID cannot meet this requirement, because the potential error rate of an unreliable diagnosis is 100%. A further guideline is that admissible evidence should be "generally accepted" in the relevant field: the controversy that has always surrounded DID means that in the US the disorder fails to meet this requirement, as well. (In Canada, it might survive attack, at least for the moment, by virtue of its' being an opinion held by a "responsible and competent body of professional opinion"; 48.) Finally, admissible evidence should be falsifiable, that is, capable of being proven wrong by empirical testing—indeed, the Court considered falsifiability to be the touchstone of science. However, no one can falsify a DID diagnosis. First, it is impossible to distinguish between personalities, identities, and personality states. Second, without general agreement about what any of the foregoing terms mean, it is impossible to prove the assertion that an individual does or does not have more than one personality (19,33). In summary, we believe that courts in the US, and perhaps some in Canada, cannot responsibly accept testimony in favour of DID.

Two further concerns follow from the foregoing discussion. First, given that most DID patients show few or no signs of the condition before treatment begins, how can one know when it has been successfully treated? (49). The second concern involves iatrogenesis. As treatment progresses, DID patients typically show more signs of alters than they did when treatment started. "It is the rule rather than the exception for previously unknown personalities to enter the treatment" (50, p 54); "many patients' personalities remain undetected by clinicians . . . until hypnosis uncovers teeming populations of them—[sometimes] more than a hundred" (34, p 138). Other writers have commented on the tendency for "the most luxuriant growth and long life of additional personalities" to occur in the protracted therapy of DID (51, p 248).

This proliferation of alters is typically accompanied by clinical deterioration that is often quite marked. In one investigation, more than 8 of 10 patients "developed florid posttraumatic stress disorder during [DID therapy]"; the authors commented that this result is typical (6, p 361). Hallucinations, increasing discomfort, and severe dysphoria often cause patients to be in states of chronic crisis for long periods of time after DID treatment begins (9,11,52–54). Moreover, suicide attempts may occur in the weeks following the diagnosis: Fetkewicz and associates showed that, after the diagnosis had been made, MPD-diagnosed patients attempted suicide more frequently than age- and sex-matched patients suffering from major depressive disorder (55). In another study, 4 of 5 MPD patients improved dramatically when they were rediagnosed and treated in more conventional ways (56).

Such deterioration should surprise no one, given the treatment practices that leading DID proponents recommend. These proponents believe that successful treatment requires DID patients to search their memories for each supposed trauma and then to abreact (that is, experience in therapy) the memories and associated emotions (1,11,57). Such searches frequently consume hours of each day, and the abreactions are extremely draining (58,59). Patients thus sink ever more deeply into a swamp of ruminations about past mistreatment, abuse, and trauma. Such immersion, of course, deepens depression. It also increases the likelihood that patients will come to believe that some noxious event actually happened to them, even if it did not. In other words, patients may develop distressing pseudomemories (60–62).

As Lilienfeld and colleagues remarked, "We are hard-pressed to identify another DSM-IV disorder whose essential feature (viz, multiple identity enactment) is often or usually unobservable prior to treatment, and [then] tends to emerge and become considerably more florid during treatment. These 2 observations probably help explain why iatrogenesis has long been a serious concern in the DID literature" (3, p 512).

Is Iatrogenesis the Royal Road to DID?

DID practitioners have long been bedevilled by suspicions that they foster or create the very pathology they treat (63,64). These practitioners respond by arguing that "full MPD" (63, p 84) or the "full and sustained picture of DID/MPD" (65, p 358) cannot be created iatrogenically. However, this response is unconvincing, because nothing in the DID literature explains what "full" and "sustained" mean; proponents have never specified the limits to the multiplicity concept. Rather, proponents say, DID is distinguished from all other psychiatric syndromes by its 2 essential and defining characteristics: alternating separate and distinct personalities and multiple amnesic episodes (11,20).

That these 2 characteristics can be iatrogenically created is beyond dispute. Numerous citations in the DID literature document that personality creation occurs (13,64–68). Bliss deliberately created 1 alter, and Leavitt deliberately created 2 (10,68). Further, Spanos and colleagues easily induced both amnesia and the sense of separate personalities in DID-naive subjects (69,70).

We have examined above the therapeutic interventions DID proponents employ. What of their diagnostic interventions? Proponents say that the fundamental step is to be watchful: "It is productive to err on the side of overconsideration of the diagnosis" (45, p 6); "It is important to maintain a high index of suspicion regarding the possibility of covert [alter emergences] during sessions with a patient" (12, p 82). DID-focused practitioners consider numerous behaviours to be possible signals of patients' alters: glancing around the therapist's office; momentarily falling silent; frequently blinking the eyes or rolling them upward; changing posture or voice pitch, rate, or volume; showing any changes of affect; covering the mouth; allowing the hair to fall over the face; scratching an itch; changing hairstyles between sessions; or wearing a particular colour of clothing or item of jewelry (15, p 82–6 and p 118–23;71;72).

We cannot too strongly criticize the practice of employing lengthy lists of a disorder's possible signs or symptoms without specifying how many positive responses are needed to cross diagnostic thresholds (20). Loewenstein's 39-item list of possible signs of MPD is noteworthy (71), but the dissociative disorders literature contains several others (18,26,72,73). Using such lists inflates the number of false-positive diagnoses.

Regardless of how many clues to multiplicity the patient shows, proponents say DID cannot be diagnosed until the clinician meets an alternate personality (74,75). To do so, Putnam recommends asking one to emerge: "I would like to talk directly to that part [aspect, point of view, side, etc] of you that came out last Wednesday at work and told your boss to stuff it" (12, p 91).

Usually, however, the alter does not "pop out the first time the therapist asks," so even if the patient "appear[s] to be extremely distressed" by persistent attempts, the therapist should "repeat the request several times" (12, p 92). How long should the clinician persist? "It may be necessary to spend a large part of the day with some [patients]" (12, p 86); Kluft recommends extending diagnostic interviews for 4 (45) or even 8 hours, during which time interviewees "must be prevented from taking breaks to regain composure [or from] averting their faces to avoid self-revelation" (42, p 115).

Proponents urge practitioners to wait as long as 6 months for the alter to emerge, because these entities are thought to be wily and secretive, sometimes entering "inner hibernation" to hide from therapists (32, p 112), "masquerading as each other in order to trick the clinician" (76, p 746), or "speaking to the host inwardly to advise how to frustrate [clinicians'] inquiries" (77, p 625). Nevertheless, proponents argue, failure to elicit an alter, even after 6 months, should not irrevocably rule out the diagnosis of MPD. Why? Because "a strong alter . . . who wish[es] to conceal the multiplicity can do so for prolonged periods." Kluft once spent years treating an alternate that "had been out continuously for 29 years" and that he thought was the host [18, p 221).

If even one alter personality finally appears, the therapist must search for others: "no parts of the self are to be arbitrarily excluded from therapy" (2, p 42). According to the theory, finding even one alter confirms the diagnosis (78); the condition's dividedness results from repeated traumas, which necessarily created not just one but many personalities; and all the secret traumas that each alters supposedly holds must be unearthed. Therefore, treatment of DID requires years of psychotherapy.

These diagnostic interventions thus close a circle of reinforcement. They encourage some patients to manifest behaviours that are attributed to alters; the behaviours convince the therapist that the DID diagnosis is correct; and the therapist then employs the treatment interventions described above, causing those patients to manifest more features of DID. As Lilienfeld and colleagues conclude, "the consilience of evidence across [several] sources of data appears to provide an impressive, if not compelling, circumstantial case for [iatrogenesis] in DID" (3, p 519).

Overview, Conclusions, and a Guess About Timing

This paper has demonstrated that the posttraumatic theory of MPD is incompatible with the evidence. Wherever we look—whether at the posttraumatic model; at theories of repression; at the epidemiologic uncertainties and aggrandizements of the disorder; at the persistent proliferation of personalities; at the elusive data that attempt to sustain the claims of exceptional abuse; at the bland presentation of breathtaking assumptions such as cross-sex, cross-species, or cross-ethnic alters; or at the impossibility of proving almost any of the basic claims of the disorder—we encounter propositions that appear to be founded on beliefs and not on facts or logic. That such beliefs could prosper in a society or a discipline represents an embarrassing weakness of the academic and professional establishment of psychiatry.

Perhaps the closest example of another culture-bound movement that resembles the modern DID–MPD movement occurred in the late 19th and early 20th centuries, when mediums and spiritist practices were popular. Hacking notes that

"multiple personality has long had close links with spiritism and reincarnation. Some alters, it has been thought, may be spirits who find a home in a multiple; mediums may be multiples who are hosts to spirits" (79, p 48). Much of the best turn-of-the-century English-language research on multiple personality was published by the London- or Boston-based societies for psychical research. However,

> After 30-odd years of high times around the turn of the century, mediumship, spiritism and psychical research went into radical decline. A zone of deviancy that was hospitable to multiple personality severely contracted (79, p 48).

When it becomes suspect to recommend MPD as part of psychiatric evaluation or treatment, the condition is diagnosed less frequently. For example, Pope and colleagues (80,81) and others (82) have shown that North American psychiatrists and psychologists are abandoning the notion of MPD–DID as an acceptable diagnosis. In these circumstances, we expect that the condition will revive momentarily and die several times before it finally ceases to be a ripple on the surface of the psychiatric universe. In the end, it is likely to become about as credible as spirits are today. Having attempted to rationally analyze the claims of MPD–DID, we trust that we have shown sufficient evidence to predict a steep decline in the condition's status over the next 10 years and a gradual fall into near oblivion thereafter.

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Résumé : La persistance de la folie : un examen critique du trouble dissociatif de l'identité II. La défense et le déclin du trouble de la personnalité multiple ou du trouble dissociatif de l'identité

Dans cette deuxième partie de notre examen, nous poursuivons l'étude de la nature illogique des arguments offerts à l'appui du concept du trouble dissociatif de l'identité (TDI). Nous examinons également le tort fait aux patients par les méthodes diagnostiques et de traitement des adeptes du TDI. Il est démontré que ces pratiques concrétisent les autres personnalités et par conséquent, encouragent les patients de façon iatrogène à se comporter comme s'ils avaient un soi multiple. Nous examinons ensuite les facteurs qui rendent impossible un diagnostic fiable de TDI — par exemple, la définition insatisfaisante, vague et élastique de « l'autre personnalité ». Parce que le diagnostic n'est pas fiable, nous croyons que les tribunaux canadiens et américains ne peuvent de façon responsable recevoir les témoignages en faveur du TDI. Enfin, nous concluons par une estimation de l'état de cette affection au cours des 10 prochaines années.