

DSM-III-R Revisions in the Dissociative Disorders: An Exploration of their Derivation and Rationale

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ABSTRACT

The authors describe and explore changes in the dissociative disorders included in the new DSM-III-R. The classification itself was redefined to minimize inadvertent areas of overlap with other classifications. Recent findings have necessitated substantial revisions of the criteria and text for multiple personality disorder. Ganser's Syndrome, listed as a factitious disorder in DSM-III, is reclassified on the basis of recent research as a dissociative disorder not otherwise specified. The examples for dissociative disorder not otherwise specified have been expanded to better accommodate recognized dissociative syndromes that do not fall within the four formally defined dissociative disorders. Several novel diagnostic entities and reclassifications were proposed that were rejected for DSM-III-R because there is insufficient supporting data at this point in time. These proposals identify issues that will require reconsideration for DSM-IV.

The Advisory Committee on the Dissociative Disorders was one of several such committees convened by the Work Group to Revise DSM-III to review the DSM III (American Psychiatric Association, 1980) classifications, criteria, and texts in the light of interim clinical experience and scientific findings, and recommend such changes as seemed warranted. Its members included Bennet G. Braun, M.D., Philip M. Coons, M.D., Richard P. Kluft, M.D., Frank W. Putnam, M.D., Robert L. Spitzer, M.D., Marlene Steinberg, M.D., and Janet B.W. Williams, D.S.W. This paper explores the issues considered by that committee and the reasoning that led to the revisions decided upon. The Dissociative Disorders are described on pages 269-270 of DSM-III-R (American Psychiatric Association, 1987) and on pages 253-260 of DSM-III (American Psychiatric Association, 1980). In deference to considerations of readability, this article will allow the preceding complete citations to stand in the stead of innumerable virtually identical references that are made to both DSM-III and DSM-III-R throughout its text.

DESCRIPTION OF THE DISSOCIATIVE DISORDERS

For reference purposes, the DSM-III-R Dissociative Disorders text is given, with intercalated parenthesized numbers to indicate the locations of significant changes from DSM-III that are discussed below: "The essential feature of these disorders is (1) a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness (2). The disturbance or alteration may be sudden or gradual, and transient or

chronic (3). If it occurs primarily in identity, the person's customary identity is temporarily forgotten, and a new identity may be assumed or imposed (as in Multiple Personality Disorder), or the customary feeling of one's own reality is lost and replaced by a feeling of unreality (as in Depersonalization Disorder). If the disturbance occurs primarily in memory (4), important personal events cannot be recalled (as in Psychogenic Amnesia and Psychogenic Fugue). Depersonalization Disorder has been included in the Dissociative Disorders because the feeling of one's reality, an important component of identity, is lost. Some, however, question this inclusion because disturbance of memory is absent. Although Sleepwalking Disorder has the essential features of a Dissociative Disorder, it is classified as a Sleep Disorder (5)."

ISSUES AND RESOLUTIONS

(1 and 3) DSM-III had specified that dissociative disturbances or alterations were sudden and temporary. In fact, a thorough review of the classic and recent literature (Kluft, 1988) indicates that gradual or stepwise onsets are known, and that two Dissociative Disorders, Multiple Personality Disorder and Depersonalization Disorder, as well as several forms of Dissociative Disorder not otherwise specified (NOS), commonly may run a chronic course, straining the connotation if not the denotation of "temporary." These two adjectives had often been used to distinguish Psychogenic Amnesia from organic memory disorders, but are misleading with regard to other disorders in this group.

(2) DSM-III had listed "consciousness, identity, or

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motor behavior." (p. 253). This wording had inadvertently a) deemphasized the importance of amnesia in this group of disorders, and b) by including motor behavior in this manner (although subsequent text references clarified that what was meant was the action performed during a disturbance of consciousness and/or identity), the wording had made it possible to consider Conversion Disorder a Dissociative Disorder, a stance for which arguments can be made. It will remain for future scientific investigators to reassess which course is preferable: to hew to a definition of dissociation that suggests that Conversion Disorder falls within the dissociative spectrum, or to use a more limited definition of dissociation. In the interim, the potential for confusion suggested the revisions adopted.

(3) V.S.

(4) The Omission of the crucial role of amnesia in the DSM-III introduction is redressed by the inclusion of this specific reference.

(5) DSM-III-R has reclassified Sleepwalking Disorder as a Sleep Disorder, necessitating a text change.

THE SEQUENCE OF THE DISORDERS

DSM-III-R reverses the order in which Multiple Personality Disorder, Psychogenic Fugue, and Psychogenic Amnesia were described in DSM-III. This reflects an increased awareness that Multiple Personality Disorder is in many ways both the paradigm and the most pervasive expression of the spectrum of dissociative phenomenology.

MULTIPLE PERSONALITY DISORDER

Overview

DSM-III serendipitously coincided with the publication of six major articles on Multiple Personality Disorder (Bliss, 1980; Braun, 1980; Coons, 1980; Greaves, 1980; Marmor, 1980; Rosenbaum, 1980). Within a few years a disorder thought to be rare, apocryphal, or even extinct emerged as a long neglected, underdiagnosed, and frequently misdiagnosed condition, highly associated with significant childhood traumatization, and rather responsive to intensive (and often long-term) psychotherapy. Many patients long thought to have other disorders and relatively unresponsive to the therapies appropriate for those disorders have proven to have this condition. Putnam, Guroff, Silberman, Barban and Post (1986) found that 100 Multiple Personality Disorder patients had averaged 6.8 years between their first mental health assessment for problems referable to this condition and their receiving an accurate diagnosis; during this period they had received an average of 3.6 erroneous diagnoses. Kluft (1985) reviewed the longitudinal histories of over 200 such patients and was able to construct a "natural history" of Multiple Personality

Disorder. Although this disorder remains controversial, the emerging literature, summarized in recent reviews (Kluft, 1987a, 1987e) clearly has demonstrated the need to revise many long-held beliefs about this condition and its manifestations. DSM-III-R moved to incorporate the most robust of the recent findings.

CRITERIA

The DSM-III criteria are: "A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time. B. The personality that is dominant at any particular time determines the individual's behavior. C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships (p. 259)." These criteria were reasonable and straightforward given the data base available at the time (the late 1970s), but are oversimplistic and misleading in the context of current knowledge. Their literal interpretation and application introduces a strong albeit inadvertent bias toward false negative diagnosis.

Criterion A mistakenly implies that at any given time, one personality is dominant. In fact, periods of mixed, shared, contested, or rapid and unstable alternating dominance are commonly seen in many cases. Criterion B is potentially confusing. The personality that appears to be dominant and may represent itself as dominant may in fact be strongly influenced by another, of whose influence it may or may not be aware. One ironic outcome of these circumstances is that Multiple Personality Disorder patients who are able to give an accurate account of their subjective experience of these processes may appear to violate the diagnostic criteria of this disorder even as they offer a classic description of its phenomena in action. A second is that the personalities' experiences of one another's impact may take the form of hallucinations, illusions, and passive influence experiences, leading the clinician to believe that they suffer a psychotic or borderline condition (Kluft, 1987b). Criterion C is problematic. The degree of elaboration and complexity of the separate entities has proven to be an expression of the interaction style of the personalities, the structure of the dissociative defenses, overall adaptive patterns, and character style of the individual patient rather than a core criterion of the illness. For example, a patient may have such extensive dividedness that this criterion is not fulfilled, the personalities may find it adaptive to pass for one another in social circumstances, the personalities may choose to influence one another covertly without emerging, a high-functioning patient may restrict the personalities' overt emergence to private moments, a creative person may apply that creativity to the elaboration of the personalities while a less creative one may not, etc. The Committee took note of the fact that the publicity accorded to certain patients with this disorder who are quite creative has unduly influenced clinicians' expectations about this population.

All three criteria suffer from problems with the term "personality." Although this term is a traditional usage, its employment in this context is confused by its different meanings within the literature of the mental health sciences. The Committee considered adopting Braun's (1986a, 1986b) nomenclature for the quantification of the degree of elaboration of the personalities, but decided to incorporate the thrust of his observations without introducing a novel set of terminology as well. In brief, Braun observed that personalities differed widely in the degree to which each had a firm sense of self, a characteristic pattern of behavior and responses, a range of functions, a range of emotions, and a significant life history of its own existence. DSM-III-R acknowledges this spectrum by indicating that the patient may have "personalities" or "personality states," but adopting the use of "personality" throughout the text. The issue is further complicated by Kluff's (1985a) longitudinal studies, which documented that many personalities were not rigidly consistent, but both evolved and changed over time.

Reflecting the above considerations, the DSM-III-R criteria become: "A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self). B. At least two of these personalities or personality states recurrently take full control of the person's behavior." The "spectrum" issue is addressed further in the elaboration of Dissociative Disorder NOS to include: "cases in which there is more than one personality state capable of assuming executive control of the individual, but not more than one personality state is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete executive control." These changes incorporate the major 1980-1987 findings in this area.

There was considerable discussion as to whether amnesia should be considered a diagnostic criterion for MPD. Coons (1980, 1984) has argued that it is a prerequisite, and the NIMH Research Criteria (Putnam, personal communication, 1985) include it. Although amnesia is present in some form in the majority of such patients, it is generally recognized that it is often denied on initial inquiry and only acknowledged later on. Also, many of these patients are unaware of their amnesia and consequently cannot report it; they have a variety of selective amnesia that Kluff (1985a, 1987a) has termed "amnesia for amnesia." Also, any of a number of amnesic patterns may prevail (Ellenberger, 1970). Furthermore, many traumatized children develop time distortion phenomena rather than frank amnesia (Terr, 1984), and Kluff (1985b, 1987a) has pointed to the persistence of this phenomenon in many personalities of adult MPD patients. Therefore, the inclusion of an amnesia criterion, notwithstanding substantial considerations to the contrary, was considered likely to contribute to the underdiagnosis of such cases. These considerations were elaborated in the descriptive text.

TEXT

Recent findings necessitated a massive revision of the text. The definitions of "personality" and "personality state" were explored and explained in context of newer information about childhood and extremely complex cases of this condition. It was emphasized that "approximately half of recently reported cases have ten personalities or fewer, and half have over ten (Kluff, 1984a)." Descriptions of the transition from one personality to another reflected newer awarenesses that the transition may be gradual rather than sudden, and may be triggered by idiosyncratically meaningful social or environmental cues, conflicts or plans among the personalities, and therapeutic interventions as well as psychosocial stress. The text explicates concisely the wide variety of amnesic patterns found among these patients, offers an explanation as to why they often are unable or unwilling to detail their memory difficulties, and clarifies that the several personalities' relationships to one another may take a wide variety of forms, which in turn influence the clinical manifestations of the patient's condition. Where DSM-III had suggested that, "The personalities are nearly always quite discrepant and frequently seem to be opposites," this reflects an outdated and oversimplistic view of the disorder. DSM-III-R indicates that although this may be found, the personalities "May also differ only in alternating approaches to a major problem area. . . one personality that responds to aggression with childlike fright and flight, another that responds with masochistic submission, and yet another that responds with counterattack." DSM-III-R does not include the DSM-III note that "Usually one of the personalities over the course of the disorder is dominant." It reflects a newer awareness that "At different times in the person's life, any of the different personalities may vary in the proportion of time that they control the person's behavior." This is more consistent with the longitudinal course of the disease (Kluff, 1985a).

The "Associated features" section has been somewhat revised to accommodate itself to the changes noted above, and also to address the confusing overlap of some of the phenomenology with that of other conditions. It acknowledges, "It is often unclear whether these represent coexisting disorders or merely associated features of Multiple Personality Disorder." It amends a DSM-III statement that suggests that personalities older than the actual age of the patient are unusual; such personalities, especially among younger patients, are commonly observed. It corrects an inaccuracy, that transitions are usually dramatic. While this may be true when a transition between discrepant personalities occurs or is requested in the context of therapy, in fact subtle transitions are far more common (Kluff, 1984a). Were dramatic transitions the rule, the condition would be far more easy to diagnose. The frequency of unnamed personalities and of symbolic and descriptive rather than proper names for the personalities is noted in DSM-III-R.

DSM-III had said that the onset was in early childhood or later. DSM-III-R notes that the onset is nearly invariably in childhood, but its recognition is much delayed. It reflects longitudinal data (Kluft, 1985a) that the frequency of personality switching tends to decline with increasing age. Although some optimistic outcome studies (Kluft, 1984b, 1986) suggest that a statement should be made regarding both "Course" and "Impairment" to correct the rather pessimistic statements regarding chronicity and incomplete recovery made in DSM-III, the committee, considering that these studies are robust, but, since they represent the work of a single investigator, concluded that they should be replicated prior to serving as the basis of an optimistic replacement statement in DSM-III-R. The committee concluded that the available data suggested that the pessimistic statements of DSM-III should be omitted without further comment.

A lay (e.g., Keyes, 1979) and professional (e.g., Coons & Milstein, 1986; Kluft, 1987c) literature has developed on the "Complications" of Multiple Personality Disorder. DSM-III-R indicates that self-destructive behaviors and externally-directed aggressive acts are complications, and that these patients may develop Psychoactive Substance Dependence Disorders. In the latter case, this often develops as an attempt to palliate intense dysphoria and depersonalization. The complications listed in DSM-III are now considered to be epiphenomena of the manifestations of this condition rather than complications. The wording of the "Predisposing Factors" section now reflects that studies have documented the clinical impression that this disorder follows upon child abuse or other severe emotional traumata. "Prevalence" in DSM-III read, "The disorder is apparently extremely rare." Kluft (1987a) has assembled a number of reports of large series, including the 100 patients of Putnam et al. (1986), the 20 of Coons and Milstein (1986), the over 200 of Kluft (1985a), and the unpublished raw data on a 355 patient series compiled by Schultz, Braun, and Kluft. With thousands of cases diagnosed by thousands of mental health workers currently in treatment, DSM-III-R notes conservatively that, "Recent reports suggest that this disorder is not nearly so rare as it has commonly been thought to be."

DSM-III-R modifies the DSM-III statements on "Sex Ratio" to indicate recent series show a female predominance of from three to nine women to each male, and those on "Familial Pattern" to note "that the disorder is more common in first-degree biologic relatives of people with the disorder than the general population." The latter observation is indebted to the anecdotal cross-generational observations by Kluft (1984c, 1985b), the retrospective studies of Braun (1985), and the controlled anterospective research of Coons (1985).

The "Differential Diagnosis" section reflects new awareness of the prevalence of Multiple Personality Disorder of a number of symptoms traditionally associated with schizophrenia (Kluft, 1987b), and addresses its

overlap with Borderline Personality Disorder, both in terms of shared features and the possibility of coexisting diagnoses (Horevitz & Braun, 1984). It notes the dynamics of the occurrence of complaints of "possession" among these patients. DSM-III-R corrects an error in the DSM-III discussion of the differential diagnosis with malingering. DSM-III is unduly optimistic about the use of hypnosis and sodium amobarbital in resolving such dilemmas, and inadvertently appears to endorse these measures without reservation. In fact, malingerers may be able to confuse these diagnostic measures, and, in the interim, a literature (reviewed in Kluft, 1987d) has developed surrounding this troubled and troublesome area. The committee concluded that as useful as these measures often prove to be, their implicit endorsement in DSM-III-R would not be appropriate, and the related statements were omitted.

PSYCHOGENIC FUGUE

Overview

In the interval between DSM-III and the deliberations concerning DSM-III-R, few contributions to the literature have addressed Psychogenic Fugue (Kluft, 1988). The committee noted with concern that although the criteria for Psychogenic Fugue require the "assumption of a new identity (partial or complete)," and that the new literature on Multiple Personality Disorder may well have much to contribute to the study of this phenomenon, and raise issues re: the appropriate boundaries of these two disorders, a modern literature on Psychogenic Fugue has not developed to facilitate the study of these issues. Furthermore, among clinicians, there remains considerable misgiving as to whether the new identity criterion has merit. Lacking the data to resolve these concerns, the committee made only minor revisions for this condition, and respected the misgivings noted by specifying a place within Dissociative Disorders NOS for "cases in which sudden unexpected travel and organized purposeful behavior with inability to recall one's past are not accompanied by the assumption of a new identity, partial or complete."

Criteria

Since fugues often occur in other conditions, Criterion A. now specifies that "The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past." Criterion B. remains: "The assumption of a new identity (partial or complete)." Criterion C. has been expanded to reflect an increased awareness that what may appear to be Psychogenic Fugue may prove to be a manifestation of epilepsy or Multiple Personality Disorder: "The disturbance is not due to Multiple Personality Disorder or an Organic Mental Disorder (e.g., partial complex seizures in temporal lobe epilepsy).

Text

The text is largely unrevised with the exception of "Differential Diagnosis." Here it is noted that Multiple Personality Disorder is characterized by repeated shifts

of identity, and often by a history of identity disturbance since childhood, whereas in Psychogenic Fugue the identity shift usually is limited to a single episode, and its onset generally coincides with that of the fugue. Also, a caveat is added to indicate that malingerers may sustain their behaviors even in the face of hypnosis or sodium amobarbital interviews.

PSYCHOGENIC AMNESIA

Overview

Between the publication of DSM-III and the deliberations concerning DSM-III-R, little has been written about clinical amnesia, although the scholarly study of experimental paradigms, especially by researchers in the field of hypnosis, has been vigorous. Little cross-fertilization has occurred. Little data has accumulated to suggest reason for revision of this disorder's description or diagnostic criteria.

Criteria

The criteria have been rewritten to clarify that they mean to refer to a discrete clinical episode predominated by the phenomena of amnesia, and further to alert the clinician to rule out Multiple Personality Disorder before making this diagnosis. They now read: "A. The predominant disturbance is an episode of sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. B. The disturbance is not due to Multiple Personality Disorder or to an Organic Mental Disorder (e.g., black-outs during Alcohol Intoxication)."

Text

The text now reflects the change in the criteria, and further notes the reservations on the use of hypnosis and amyltal that were also described with respect to the differential diagnosis of Multiple Personality Disorder and Psychogenic Fugue.

DEPERSONALIZATION DISORDER

Again, a minimal interim literature has developed with regard to Depersonalization Disorder (Kluft, 1988). There continues to be concern over whether this constitutes a symptom or a syndrome, as many of its stigmata are associated with other disorders. Although depersonalization is a common symptom, the diagnosis of Depersonalization Disorder is made infrequently. The committee reviewed the available literature and reached the conclusion that the DSM-III criteria were unduly vague and, in their emphasis on the production of significant social or occupational functioning, misconstrued the predominant thrust of the literature, which emphasizes more the subjective experiences and personal distress of those afflicted. It is hoped that the result will be a more useful set of criteria that will allow the diagnosis to be made more effectively, or conversely,

may enable future researchers to determine that it is more a disorder or syndrome than a symptom per se.

Criteria

DSM-III criteria were: "A. One or more episodes of depersonalization sufficient to produce significant impairment in social or occupational functioning. B. The symptom is not due to any other disorder...." DSM-III-R attempts further clarification and rigor with: "A. Persistent or recurrent experiences of depersonalization as indicated by either (1) or (2): (1) an experience of feeling detached from, and as if one's an outside observer of, one's mental processes or body (2) an experience of feeling like an automaton or as if in a dream. B. During the depersonalization experience, reality testing remains intact. C. The depersonalization is sufficiently severe and persistent to cause marked distress. D. The depersonalization experience is the predominant feature, and is not a symptom of another disorder, such as Schizophrenia, Panic Disorder, or Agoraphobia without History of Panic Disorder but with limited symptom attacks of depersonalization, or temporal lobe epilepsy." The thrust toward a more specific definition of the disorder and a greater focus on subjective distress is self-evident.

Text

The text changes reflect changes in wording that better clarify the modified criteria and adopt somewhat more readily apprehended terminology and examples. Global generalizations of rapid onset and gradual remission were mollified to indicate that these descriptions "usually" prevailed. "Impairment" has been changed from "usually minimal" to "minimal to severe," which is felt to better reflect the clinical literature. Under "Complications" it is now recognized that some of these patients develop a Psychoactive Substance Abuse Disorder to palliate their distress. Several of the "Predisposing Factors" in DSM-III are omitted from DSM-III-R, because the committee concluded that these factors were more associated with the symptom of depersonalization than the development of depersonalization disorder. DSM-III-R indicated that "severe stress" may be a predisposing factor, consistent with Putnam's findings in a 1985 review.

DISSOCIATIVE DISORDER NOT OTHERWISE SPECIFIED

Overview

The committee perceived this classification as extremely important for contemporary psychiatry. It includes a number of disorders characterized by dissociative symptoms, and dissociative symptoms are increasingly recognized as posttraumatic phenomena (Putnam, 1985; Spiegel, 1985, 1986, in press).

Increasingly the victims of terrorism, war, torture will present for treatment, and a failure to appreciate this aspect of their difficulties will hinder their treatment

and rehabilitation. As will be discussed below, the relationship between the Dissociative Disorders and Posttraumatic Stress Disorder deserves intense study and aggressive exploration. Furthermore, this classification may encompass many of the manifestations of the highly hypnotizable patient, and the study of this group of individuals is an exciting area still in its infancy. A number of syndromes currently classified elsewhere or described in the literature of psychiatric anthropology may nest under this heading (Kluft, 1987e). These observations reflect the committee's deliberations, but, because they are speculative and anticipatory, are not reflected in the text.

Example

Most of the examples offered in DSM-III-R have been noted above or are unchanged from DSM-III. A notable exception is the inclusion of "Ganser's syndrome: the giving of approximate answers to questions, commonly associated with other symptoms such as amnesia, disorientation, perceptual disturbances, fugue, and conversion symptoms." Ganser's syndrome was previously classified as a Factitious Disorder. Between DSM-III and the committee's deliberations, Cocores, Santa, and Patel (1984) published a review of 41 cases, documenting the association of the giving of approximate answers with the dissociative phenomena noted above. At this point in time, it seemed appropriate to support this reclassification.

ALTERATIONS PROPOSED BUT NOT ADOPTED

A proposal was received that suggested that the Dissociative Disorders be reconceptualized as disorders of autohypnosis, occurring along a spectrum of degree of severity. The committee reviewed the supporting data and rejected this proposal on three grounds. First, the basis of classification in DSM-III-R is, to as great an extent as is possible, phenomenologic rather than etiologic. Second, the role of the purported mechanism in the formation of some of these disorders has not been explored; this is a theory most commonly associated with Multiple Personality Disorder (e.g., Bliss, 1986). Consequently this type of consideration could not become part of the overall text for the Dissociative Disorders. Third, this is only one of several conceptualizations currently being proposed to explain some of the Dissociative Disorders, none of which has attained general acceptance, and all of which remain controversial.

Proposals were received to create separate classifications for patients who have syndromes that have the same structure as Multiple Personality Disorder, but with less overt manifestations, and for children with such a condition in its incipient phase (e.g., Fagan and McMahon, 1984) or in the process of evolving toward the adult form (e.g., Kluft, 1984c, 1985b). The committee acknowledged that these conditions exist and have been documented, but that at this time the evidence remains

too preliminary to serve as the basis of new classifications. Longitudinal data suggests that they may all prove to be phases of the same disorder (Kluft, 1985a). A decision was made to refer to the differences between adult and childhood cases in the descriptive text for Multiple Personality Disorder, and to include examples under Dissociative Disorder NOS that explicitly acknowledged less overtly manifested conditions.

Proposals were received to create classifications for a Possession Disorder, a Trance State Disorder, and a combined Trance/Possession Disorder that would be diagnosed if either of the above was noted. The committee acknowledged that a number of patients present with trance-like states, but noted that: a) no literature on the subject had developed to allow the serious consideration of a new category; and, b) DSM-III had already acknowledged such cases under Atypical Dissociative Disorder (Dissociative Disorder NOS in DSM-III-R). A description of such cases became an example of Dissociative Disorder NOS. With regard to Possession Disorder, there was considerable debate, and the committee sought the advice of additional consultants. Indeed, numerous well-authenticated and extensively documented culture-bound dissociative conditions exist and are known in the literatures of transcultural psychiatry and anthropological psychiatric inquiry. There was little doubt that such a heading would be useful to some scientific investigators. However, the large number of such syndromes makes their separate listing a logistic impossibility. Some concern was expressed that incorporating such a disorder might appear to legitimize literal demonic possession as a genuine clinical entity, prompting consideration of the unwieldy but less inflammatory term, Possessioniform Disorder. The matter was resolved, after consultation, by a strict application of the phenomenologic approach. Most possession syndromes are isomorphic with either Multiple Personality Disorder, Psychogenic Fugue, or examples given under Dissociative Disorder NOS. Consequently, pending the development of data that would show such a disorder is phenomenologically different from these conditions, its addition would be redundant. The committee noted that there is a relevant historical consideration here. Multiple Personality Disorder and its attenuated forms are, historically, the secularized descendants of the Judeo-Christian possession syndrome (Ellenberger, 1970).

There was considerable discussion regarding the possible reclassification of Posttraumatic Stress Disorder from the Anxiety Disorders to the Dissociative Disorder section in DSM-III-R. The basis for this proposal was that many of the symptoms that occur in Posttraumatic Stress Disorder are dissociative in nature, and that the essential feature of Dissociative Disorders, "a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness," is operative in situations in which the mind is impaired in its capacity to contain memories (as well as in its capacity to seques-

ter memories (amnesia). The cycles of numbing and intrusive phenomena (Horowitz, 1986) in Posttraumatic Stress Disorder are consistent with a dissociative process. Furthermore, split identity processes are noted in many sufferers of Posttraumatic Stress Disorder (Brende, 1985). A number of scientific investigators have conceptualized certain Dissociative Disorders as variants of Posttraumatic Stress Disorder (Kluft, 1987a; Putnam, 1985; Spiegel, 1984, 1986). There are thought-provoking findings that many veterans suffering Posttraumatic Stress Disorder have high hypnotizability (Stutman & Bliss, 1985; Spiegel, unpublished data) and that Posttraumatic Stress Disorder patients score high on the Dissociative Experiences Scale (Bernstein & Putnam, 1986). Arguments offered against such a reclassification consisted largely of strongly-worded opinions and expressions of concern for the non-scientific consequences of such an action. Substantive complaints centered around dissatisfactions with the DSM-III and DSM-III-R definitions of dissociation (primarily that it is too broad), and concerns that little objective data have been assembled. The Committee was faced with wide differences of opinion. Furthermore, this proposal was made at a fairly advanced stage of the revision process, and logistic and time pressures made efforts to reach a firm resolution on solid scientific grounds difficult. The Committee took under consideration that the data

supporting the proposed changes were relatively new and remained to be replicated. The Committee was also aware that research already in progress and newer ways to conceptualize, describe, and measure dissociation were on the horizon (Bernstein & Putnam, 1986; Braun, 1988; Sanders, 1986), and that structured interviewing instruments to facilitate the more objective study of the Dissociative Disorders will soon be available, (e.g., Steinberg, Howland, & Cicchetti, 1986; Heber et al., 1987; Dyke & Gillette, 1987). Anticipating that scientific advances in the near future are likely to explore and resolve the areas currently regarded as problematic, the Committee and the Work Group decided against a reclassification at this point in time, and suggested that the same issue could be approached with more data during the deliberations for DSM IV.

DISCUSSION

The Dissociative Disorders are the subject of considerable contemporary clinical and research interest, but their study is a relatively new field of inquiry. The committee attempted to incorporate the most reliable and valid insights of the newer clinical and research findings and the most cogent feedback from a wide variety of sources. It is anticipated that the DSM-III-R criteria and text will require additional revision as psychiatry further explores this group of conditions.

REFERENCES

- American Psychiatric Association. (1980). *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3rd Edition)*. Washington, D.C.: Author.
- American Psychiatric Association (1987). *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3rd edition, revised)*. Washington, D.C.: Author.
- Bernstein, E.M., & Putnam, F.W. (1986). *Development, reliability, and validity of a dissociation scale*. *JOURNAL OF NERVOUS AND MENTAL DISEASE*, 174, 727-735.
- Bliss, E.L. (1980). *Multiple personalities: A report of 14 case with implications for schizophrenia and hysteria*. *ARCHIVES OF GENERAL PSYCHIATRY*, 37, 1388-1397.
- Bliss, E.L. (1986). *MULTIPLE PERSONALITY, ALLIED DISORDERS, AND HYPNOSIS*. New York: Oxford.
- Braun, B.G. (1980). *HYPNOSIS FOR MULTIPLE PERSONALITIES*. In H.J. Wain (Ed.), *HYPNOSIS IN CLINICAL MEDICINE* pp. 209-217. Chicago: Year Book Medical Publishers.
- Braun, B.G. (1985). *The transgenerational incidence of dissociation and multiple personality disorder: A preliminary report*. In R.P. Kluft (Ed.), *CHILDHOOD ANTECEDENTS OF MULTIPLE PERSONALITY DISORDER*, Washington, D.C.: American Psychiatric Press.
- Braun, B.G. (1986a). *Introduction*. In Braun, B.G. (Ed.), *TREATMENT OF MULTIPLE PERSONALITY DISORDER*. Washington, D.C.: American Psychiatric Press.
- Braun, B.G. (1986b). *Introduction to the psychotherapy of multiple personality disorder*. In Braun, B.G. (Ed.), *TREATMENT OF MULTIPLE PERSONALITY DISORDER*, Washington, D.C.: American Psychiatric Press.
- Brende, J.O. (1984). *The psychophysiological manifestations of dissociation*. In B.G. Braun (Ed.), *SYMPOSIUM ON MULTIPLE PERSONALITY, PSYCHIATRIC CLINICS OF NORTH AMERICA*, 7, 41-50.
- Cocores, J.A., Santa, W.G., & Patel, M.D. (1984). *The Ganser syndrome: Evidence suggesting its classification as a dissociative disorder*. *INTERNATIONAL JOURNAL OF PSYCHIATRY IN MEDICINE*, 14, 47-56.
- Coons, P.M. (1980). *Multiple personality: Diagnostic considerations*. *JOURNAL OF CLINICAL PSYCHIATRY*, 41, 330-336.
- Coons, P.M. (1980). *The differential diagnosis of multiple personality*. In Braun B.G. (Ed.) *SYMPOSIUM ON MULTIPLE PERSONALITY, PSYCHIATRIC CLINICS OF NORTH AMERICA*. 7, 51-67.

- Coons, P.M. (1985). *Children of parents with multiple personality disorder*. In R.P. Kluft (Ed.) *CHILDHOOD ANTECEDENTS OF MULTIPLE PERSONALITY DISORDER*. Washington, D.C.: APA Press.
- Coons, P.M., & Milstein, V. (1985). *Psychosexual disturbances in multiple personality: Characteristics, etiology, and treatment*. *JOURNAL OF CLINICAL PSYCHIATRY*, 47, 106-110.
- Dyck, P.B., & Gillette, G.M. (1987). *Development of a dissociative symptom inventory*. In B.G. Braun (Ed.), *DISSOCIATIVE DISORDERS*, 1987. Chicago: Rush University.
- Ellenberger, H. (1970). *THE DISCOVERY OF THE UNCONSCIOUS*. New York, Basic Books.
- Fagan, J., & Mc Mahon, P.P. (1984). *Incipient multiple personality in childhood: Four cases*. *JOURNAL OF NERVOUS AND MENTAL DISEASE*, 172, 26-36.
- Greaves, G.B. (1980). *Multiple personality: 165 years after Mary Reynolds*. *JOURNAL OF NERVOUS AND MENTAL DISEASE*, 168, 577-596.
- Heber, S., Ross, C.A., Norton, R., Anderson, D., Anderson, G., & Barchet, P. (1987). *The dissociative disorders interview schedule: A structured interview*. In B.G. Braun (Ed.), *DISSOCIATIVE DISORDERS*, 1987. Chicago: Rush University.
- Horevitz, R.P., & Braun, B.G. (1984). *Are multiple personalities borderline?* *SYMPOSIUM ON MULTIPLE PERSONALITY, PSYCHIATRIC CLINICS OF NORTH AMERICA*, In B.G. Braun (Ed.), 7, 69-87.
- Horowitz, M.J. (1986). *Stress response syndromes (2nd ed.)*. New York: Aronson.
- Keyes, D. (1981). *The minds of Billy Milligan*. New York: Random House.
- Kluft, R.P. (1984a). *An introduction to multiple personality disorder*. *PSYCHIATRIC ANNALS*, 14, 19-24.
- Kluft, R.P. (1984b). *Aspects of the treatment of multiple personality disorder*. *PSYCHIATRIC ANNALS*, 14, 51-55.
- Kluft, R.P. (1984c). *Multiple personality in childhood*. In B.G. Braun (Ed.), *SYMPOSIUM ON MULTIPLE PERSONALITY, PSYCHIATRIC CLINICS OF NORTH AMERICA*, 7, 121-134.
- Kluft, R.P. (1985a). *The natural history of multiple personality disorder*. In R.P. Kluft (Ed.), *CHILDHOOD ANTECEDENTS OF MULTIPLE PERSONALITY*, Washington, D.C.: American Psychiatric Press.
- Kluft, R.P. (1985b). *Childhood multiple personality disorder: Predictors, clinical findings, and treatment results*. In R.P. Kluft (Ed.), *CHILDHOOD ANTECEDENTS OF MULTIPLE PERSONALITY*, Washington, D.C.: American Psychiatric Press.
- Kluft, R.P. (1986). *Personality unification in multiple personality disorder: A follow up study*. In B.G. Braun (Ed.), *TREATMENT OF MULTIPLE PERSONALITY*, Washington, D.C.: American Psychiatric Press.
- Kluft, R.P. (1987a). *An update on multiple personality disorder*. *HOSPITAL AND COMMUNITY PSYCHIATRY*, 38, 363-373.
- Kluft, R.P. (1987b). *First rank symptoms as a diagnostic clue to multiple personality disorder*. *AMERICAN JOURNAL OF PSYCHIATRY*, 144, 293-298.
- Kluft, R.P. (1987c). *The parental fitness of mothers with multiple personality disorder: A preliminary study*. *CHILD ABUSE & NEGLECT, THE INTERNATIONAL JOURNAL*, 11, 273-280.
- Kluft, R.P. (1987d). *The simulation and dissimulation of multiple personality disorder*. *AMERICAN JOURNAL OF CLINICAL HYPNOSIS*, 30, 104-118.
- Kluft, R.P. (1987e). *Dissociative Disorders*. In A.E. Skodol & R.L. Spitzer (Eds.), *AN ANNOTATED BIBLIOGRAPHY OF DSM-III (119-124)*. Washington, D.C.: American Psychiatric Press.
- Kluft, R.P. (1988). *Dissociative disorders*. In R.E. Hales & S. Yudofsky (Eds.), *AMERICAN PSYCHIATRIC PRESS TEXTBOOK OF PSYCHIATRY*. Washington, D.C.: American Psychiatric Press.
- Marmer, S.S. (1980). *Psychoanalysis of multiple personality*. *INTERNATIONAL JOURNAL OF PSYCHOANALYSIS*, 61, 439-459.
- Putnam, F.W. (1985). *Dissociation as a response to extreme trauma*. In R.P. Kluft (Ed.), *CHILDHOOD ANTECEDENTS OF MULTIPLE PERSONALITY*, Washington, D.C.: American Psychiatric Press.
- Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). *The clinical phenomenology of multiple personality disorder: Review of 100 recent cases*. *JOURNAL OF CLINICAL PSYCHIATRY*, 47, 285-293.
- Sanders, S. (1986). *The perceptual alteration scale: A scale measuring dissociation*. *AMERICAN JOURNAL OF CLINICAL HYPNOSIS*, 29, 95-102.
- Spiegel, D. (1984). *Multiple personality as a post-traumatic stress disorder*. In B.G. Braun (Ed.), *SYMPOSIUM ON MULTIPLE PERSONALITY PSYCHIATRIC CLINICS OF NORTH AMERICA*, 7, 101-110.
- Spiegel, D. (1986). *Dissociation, double binds, and posttraumatic stress in multiple personality disorder*. In B.G. Braun (Ed.), *TREATMENT OF MULTIPLE PERSONALITY*, Washington, D.C.: American Psychiatric Press.
- Terr, L.C. (1984). *Time and trauma*. *PSYCHOANALYTIC STUDY OF THE CHILD*, 39, 633-665.
- Steinberg, M., Howland, F., & Cicchetti, D. (1986). *The structured clinical interview for DSM-III-R dissociative disorders: A preliminary report*. In B.G. Braun (Ed.), *DISSOCIATIVE DISORDERS: 1986*, Chicago: Rush University.
- Stutman, R., & Bliss, E.L. (1985). *The post-traumatic stress disorder (the Viet Nam syndrome), hypnotizability, and imagery*. *AMERICAN JOURNAL OF PSYCHIATRY*, 142, 741-743.