

# EVIDENCE AGAINST THE IATROGENESIS OF MULTIPLE PERSONALITY DISORDER

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## ABSTRACT

*The authors present data which argue against the iatrogenesis of multiple personality disorder (MPD). Twenty-two cases reported by one Canadian psychiatrist, 23 cases reported by a second Canadian psychiatrist, 48 cases seen by 44 American psychiatrists specializing in MPD, and 44 cases seen by 40 Canadian general psychiatrists without a special interest in MPD are compared. The Canadian general psychiatrists had seen an average of 2.2 cases of MPD, while the Americans had seen an average of 16.0. There were no differences between these groups on the diagnostic criteria for MPD or the number of personalities identified. Specialists in MPD are not influencing their patients to create an increased number of personalities or to endorse more diagnostic criteria. Exposure to hypnosis does not appear to influence the phenomenology of MPD.*

Since the nineteenth century (Binet, 1896; Ellenberger, 1970), there have been suspicions that multiple personality disorder (MPD) is the iatrogenic product of the relationship between a suggestible patient and a misguided therapist. Binet (1890, 1896) and others demonstrated the artificial production of dissociated states in the nineteenth century. In the 1940s a review article (Taylor & Martin, 1944) dealt with iatrogenesis and a series of papers (Harriman, 1942a; Harriman, 1942b; Harriman, 1943; Leavitt, 1947) demonstrated that analogs of some of the features of MPD can be induced experimentally in normal highly-hypnotic volunteers. Recent work has confirmed these findings with more rigorous experiments (Kampman, 1976; Spanos, Weekes & Bertrand 1985; Spanos, Weekes, Menary & Bertrand, 1987).

The belief that MPD is an iatrogenic artifact has no support from the study of actual MPD patients, however. On the other hand, there are no data from a large series of MPD cases which argue against iatrogenesis. To date the best argument against the iatrogenesis of MPD is based on extensive clinical experience (Braun, 1984; Kluff, 1982; Kluff, 1987).

In the context of this controversy, we collected 236 cases of MPD reported to us by 203 clinicians throughout North America, who had jointly seen 1807 cases (Ross, Norton & Wozney, 1989). The 236 cases included 44 cases seen by 40 general Canadian psychiatrists, and 48 cases seen by 44 American psychiatrists specializing in MPD who are members of the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D). The remainder of the 236 cases were reported by psychologists and other non-medical therapists.

In addition we gathered data on 22 cases of MPD seen by one Canadian psychiatrist, and 23 cases seen by a second Canadian psychiatrist, both of whom are members of ISSMP&D. We thought it would be instructive to study single caseloads of two Canadian specialists in MPD, to determine whether their patients differ from cases seen by generalist colleagues.

We compared the four groups of MPD cases to determine their differences and similarities. We hypothesized that if MPD is due to iatrogenesis, then specialists in MPD ought to exert this influence more strongly than general psychiatrists. If MPD is due to iatrogenesis, the following should be observed:

1. Cases seen by Canadian general psychiatrists will have fewer personalities than those seen by ISSMP&D specialists.
2. Cases seen by Canadian general psychiatrists will have been in the mental health system longer prior to diagnosis than cases seen by ISSMP&D specialists, because the Canadians will not be so quick to create MPD in their patients.
3. Cases seen by Canadian general psychiatrists will meet the NIMH diagnostic criteria less often than those seen by ISSMP&D specialists, because specialists are more familiar with these criteria, and more likely to cue their patients to report them.

## METHOD

### Subjects

Subjects were 236 cases of MPD described in previous reports (Ross and Norton, 1988; Ross, Norton & Wozney, 1989). In addition to the 236 cases, data were gathered on 22 cases seen by one Canadian psychiatrist, and 23 seen by a second Canadian psychiatrist.

### Procedure

A 36-item questionnaire was mailed to 1,729 members of the Canadian Psychiatric Association and 515 members of the ISSMP&D. Each respondent was asked to indicate whether he or she had ever worked with an MPD patient. Those who had were asked to complete the questionnaire on one or more of their recent patients.

The questionnaire obtained information about (a) training of the respondent and experience with MPD, (b) demographic characteristics of the patient, (c) how well the patient met the DSM-III-R and NIMH criteria (Putnam, personal communication) for MPD, (d) number and characteristics of the patient's alter personalities, (e) the abuse history of the patient, (f) previous diagnoses, previous treatment, and criminal activities of the patient, and (g) the number of Schneiderian first-rank symptoms of schizophrenia experienced by the patient.

A total of 262 cases was reported by 227 respondents. Of these, seven were excluded because of incomplete data, and five were excluded because one or more answers by the respondents relating to the number of cases seen or the number of patient personalities were determined to be statistical outliers ( $p < .01$ ). Finally, 14 cases were excluded because the characteristics of the patients did not meet the DSM-III-R criteria for MPD, leaving a total sample of 236 cases.

From the total of 236 cases, we identified 44 cases of MPD seen by 40 Canadian psychiatrists who are members of the Canadian Psychiatric Association, five of whom also belong to the ISSMP&D. We also identified 48 cases of MPD seen by 44 American psychiatrists who are members of the ISSMP&D. The cases reported by the five Canadian psychiatrists who also belong to ISSMP&D were retained in the Canadian group.

The same questionnaire was then used to gather data on 22 cases seen by one Canadian psychiatrist, and 23 cases seen by a second Canadian psychiatrist. These two psychiatrists live in different cities, both are members of ISSMP&D, and neither has met a patient in the other's caseload. No cases seen by these two physicians were included in the series of 236.

The data for the 45 additional cases were gathered by research assistants. The research assistants were blind to the characteristics of the subjects in the series of 236 cases. As well, the psychiatrist reporting 23 cases was blind to the series of 236. Data were gathered by the research assistants through direct knowledge of the subjects, study of their charts, and consultation with these patients' psychiatrists to clarify a number of details.

Data on the four groups were analyzed using chi squares for dichotomous data and *t* tests for continuous data. Two-tailed *t* tests were used because we did not know in advance in which direction groups would differ from each other. We used *t* tests and chi squares because we wanted to detect existing differences between particular groups. Consistent with our three initial hypotheses, we were primarily concerned with differences between the patients seen by Canadian general psychiatrists and the other three groups. We were not primarily concerned with an omnibus statistical

measure of whether or not any groups differ on a given dependent variable, a question for which analysis of variance is the appropriate statistical test.

### RESULTS

The independent variables in this study are the four different groups (Ross, Fraser, American psychiatrists, Canadian psychiatrists). According to the hypotheses stated in the introduction, the dependent variables should differ between groups if iatrogenesis is occurring.

The dependent variables are the clinical characteristics of the patients discussed in the hypotheses: number of personalities, years in the mental health system prior to diagnosis, and the diagnostic criteria for MPD.

In addition, several other sets of data are presented. The characteristics of the respondents are described to demonstrate that the Canadian general psychiatrists have in fact treated fewer cases of MPD than the ISSMP&D specialists.

The demographic characteristics, abuse histories, and exposure to hypnosis of the patients are described as well. These items are presented for completeness, and because any observed differences between groups on the dependent variables might be attributed to differences on these features.

The four groups will be referred to as follows: by the names of the two individual psychiatrists, Ross ( $N=22$ ) and Fraser ( $N=23$ ), as Canadian psychiatrists ( $N=44$ ), and as American psychiatrists ( $N=48$ ).

#### Characteristics of Respondents

There were large differences between the respondents in number of cases of MPD seen. Ross had made the diagnosis of MPD 22 times, Fraser 50 times, the Canadian psychiatrists an average of 2.2 times (S.D. 1.3), and the American psychiatrists an average of 16.0 times (S.D. 33.6). In number of cases seen, Canadian and American psychiatrists differed significantly, ( $t(46.1)=2.81$ ,  $p < .007$ ). These data are shown on Table 1.

There were large differences between the respondents in number of cases currently in treatment. Ross had 3 cases in treatment, Fraser had 14 cases, the Canadian psychiatrists had an average of 0.6 cases currently in treatment (S.D. 0.7), and the American psychiatrists had an average of 2.1 cases currently in treatment (S.D. 1.7). In number of cases currently in treatment, Canadian and American psychiatrists differed significantly, ( $t(61.7)=5.29$ ,  $p < .00001$ ). These data are shown in Table 1.

Ross, the Canadian psychiatrists, and the American psychiatrists had seen their first cases of MPD in 1979 (average value for Canadian and American psychiatrists). Fraser had seen his first case in 1976.

#### Demographic Characteristics of Patients

There were no differences between the four groups on age, sex, marital status, or number of children.

There were no differences between the four groups in percentage that had worked as a prostitute, been in jail, or been convicted of a crime, with one exception: Ross' patients

had worked as prostitutes more often (36.4%) than the Canadian psychiatrists' (8.9%), ( $X^2(2)=7.82, p < .02$ ).

#### Abuse Histories of Patients

The Canadian psychiatrists reported less sexual abuse than the other three groups. The other three groups did not differ from each other on rates of sexual abuse. These rates, with statistical difference from the Canadian psychiatrists, are: Canadian psychiatrists 45.5%, Ross 77.3%, ( $X^2(2)=6.10, p < .05$ ); Fraser 87.0%, ( $X^2(2)=11.33, p < .003$ ); American psychiatrists 81.2%, ( $X^2(2)=12.83, p < .001$ ). The data on abuse are presented as percentages for ease of understanding, because the number of subjects varies between groups. Since the responses concerning abuse provided dichotomous, yes or no, answers, chi squares were used in the analysis. There were no differences between the four groups in rates of physical abuse or rape.

#### Patients' Exposure to Hypnosis

There were large differences between the four groups in exposure to hypnosis. The percentages of cases that had been hypnotized prior to diagnosis were: Ross (54%), Fraser (0.0%), Canadian psychiatrists (23.8%), and Ameri-

can psychiatrists (32.6%). In use of hypnosis prior to diagnosis, Ross did not differ from the American psychiatrists, but he differed from Fraser ( $X^2(2)=17.11, p < .0001$ ) and from the Canadian psychiatrists, ( $X^2(2)=6.57, p < .04$ ). Fraser differed from the American psychiatrists, ( $X^2(2)=13.29, p < .001$ ), and from the Canadian psychiatrists, ( $X^2(2)=8.06, p < .02$ ). The Canadian and American psychiatrists did not differ from each other. The data on hypnosis are presented as percentages for ease of understanding, but chi squares were used in the analysis, as for the analysis of abuse histories.

The percentages of cases that had been hypnotized after diagnosis were: Ross (68.2%), Fraser (100.0%), Canadian psychiatrists (57.8%), and American psychiatrists (72.9%). In use of hypnosis after diagnosis, Ross did not differ from the Canadian or American psychiatrists, but he differed from Fraser, ( $X^2(2)=8.67, p < .003$ ). Fraser differed from the American psychiatrists, ( $X^2(2)=7.63, p < .02$ ); and from the Canadian psychiatrists, ( $X^2(2)=13.48, p < .001$ ). The Canadian and American psychiatrists did not differ from each other. Data on hypnosis are shown in Table 2.

#### Characteristics of Patients' Personalities

There were no differences between the four groups in number of personalities identified at the time of diagnosis, or at the time of reporting. The average number of personalities identified at diagnosis for the entire series of 236 cases was 3.5 (S.D. 6.2); the average number identified at the time of reporting was 15.7 (S.D. 22.1).

The large amount of variability in number of personalities at diagnosis and at time of reporting is due to small number of respondents reporting cases of polyfragmented MPD. For instance one respondent, who is well known in the field, with several publications, reported a case with 300 personalities. Respondents were not asked to distinguish between personalities, personality states, and fragments.

#### Length of Time in the Mental Health System Prior to Diagnosis

Patients in all four groups had been in the mental health system a long time prior to diagnosis of their MPD. The only differences between groups in this regard were that Fraser's patients had been in the system longer than those of the Canadian psychiatrists, ( $t(34.8)=3.35, p < .002$ ); and those of the American psychia-

TABLE 1  
Differences Between Respondents in Experience with MPD

Case Reported	American Psychiatrists (N=48)	Canadian Psychiatrists (N=44)	Ross (N=22)	Fraser (N=23)
Number of Cases of MPD Diagnosed	16.0	2.2	22.0	50.0
Number of Cases of MPD Currently in Treatment	2.1	0.6	3.0	14.0

*\*figures for American and Canadian psychiatrists are means for the group*

TABLE 2  
Differences Between Groups in Exposure to Hypnosis

Case Reported	American Psychiatrists (N=48)	Canadian Psychiatrists (N=44)	Ross (N=22)	Fraser (N=23)
Percentage of Cases Hypnotized Before Diagnosis	32.6	23.8	54.5	0.0
Percentage of Cases Hypnotized After Diagnosis	72.9	57.8	68.2	100.0

trists, ( $t(37.9)=2.75, p<.008$ ). The average length of time in the mental health system from first presentation for symptoms of MPD to diagnosis for the series of 236 cases was 6.7 years. This is similar to the period of 6.8 years noted by Putnam (1986) in a series of 100 cases, and to the 6.9 years noted by Braun and Gray (1986) in a series of 126 cases.

#### Diagnostic Criteria for Multiple Personality Disorder

There were no differences between any of the four groups in percentage of cases meeting each of the five NIMH diagnostic criteria for MPD.

#### DISCUSSION

These data provide evidence against the iatrogenesis of MPD. None of the three hypotheses of the iatrogenesis theory stated in the introduction are supported by the data. If MPD were an artifact created by a small number of enthusiasts, one would expect the characteristics of cases seen by ISSMP&D psychiatrists to differ from those of general Canadian psychiatrists. The Canadian generalists have seen an average of 2.2 cases, while the American specialists have averaged 16.0 cases. Ross had seen 22 cases, and Fraser had seen 50. In terms of features specific for MPD, no such differences were observed.

There were no differences between the four groups in the number of personalities at the time of diagnosis or at the time of reporting, or in the number of subjects meeting each of five NIMH diagnostic criteria for MPD (Ross, Norton & Wozney, 1989). There were no differences between the groups in length of time patients spent in the mental health system prior to diagnosis, except that Fraser's patients were in the system longer than those reported by the American and Canadian psychiatrists. This finding is the opposite of that predicted by the iatrogenesis theory.

The lack of differences between the four groups indicates two reciprocally-related facts: the American psychiatrists have chosen representative cases from their overall caseloads; and the caseloads of Ross and Fraser are similar to cases seen throughout North America. If either Ross or Fraser were creating idiosyncratic artifacts, one would expect their caseloads to be skewed in some way. Reciprocally, if the American psychiatrists were reporting cases that are not representative of their caseloads, or of MPD patients in general, differences in the dependent variables might be observed. It was to check on such iatrogenic influence and selection bias that we compared a large number of cases from two caseloads to single cases reported by a variety of clinicians throughout North America.

The cases in the overall series of 236 were reported to us by 203 respondents who have jointly seen 1,807 cases of MPD. This fact alone demonstrates that MPD cannot be dismissed as an artifact reported by a small number of enthusiasts.

MPD cannot be dismissed as an artifact of hypnosis based on these data, because of the wide variation in use of hypnosis between groups. For instance, Fraser never hypnotizes a patient prior to gathering a complete history in the first session. In the second session he administers a hypnotic

induction profile (Spiegel & Spiegel, 1977) prior to contact with alter personalities. Ross' practice is much more variable, and he does not administer hypnotic induction profiles. If MPD is an artifact of hypnosis, then the varying exposure of the four groups to hypnosis should have resulted in different features. This was not the case.

The subjects in the four groups do not differ demographically. This finding provides indirect evidence against iatrogenesis, if one assumes based on the iatrogenesis theory that MPD specialists are creating MPD artifactually in a susceptible sub-population of patients, such as young women.

The patients seen by Canadian general psychiatrists had experienced less sexual abuse, but not less physical abuse and rape, than those in the other three groups. We are puzzled by this finding of less sexual abuse reported by Canadian generalists, but do not consider it to weigh in favor of iatrogenesis, because of the lack of differences in the dependent variables.

One caution is necessary in interpreting these findings. That is the lack of independent validation of the diagnoses of MPD using reliable diagnostic instruments. Twenty of the 22 patients reported by Ross in this study, however, were subjects for development of the Dissociative Disorders Interview Schedule (Heber et al., 1987). This structured interview has an inter-rater reliability of 0.68. It has a sensitivity of 90% and specificity of 100% for the diagnosis of MPD. It also has good clinical validity. Since Ross' caseload does not differ from the other three groups, one can assume that they too would score positively for both the diagnosis and the secondary features of MPD on structured interview.

Further, 17 of the 22 subjects reported by Ross in this study participated in a replication study of the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986). In this replication study the DES discriminated MPD from schizophrenia, eating disorders, panic disorder, chemical dependency, and medical student controls (Ross, Norton & Anderson, 1988). One group in the current study has therefore had its diagnostic status confirmed by valid and reliable structured interview and self-report.

A second limitation of the study is the fact that data on Ross' and Fraser's cases were not gathered in the same way as for the American and Canadian psychiatrists. Ross' and Fraser's cases were included for the reasons stated above, despite this unavoidable difference in the way the data were collected.

The study also suffers from the limitations of questionnaire methodology. However, the imprecision of the questionnaire method does not invalidate the results; if anything, a questionnaire might be expected to amplify any iatrogenic bias or idiosyncrasy in the respondents. If this is the case, then the data argue even more strongly against the iatrogenesis of MPD.

There is no evidence derived from the study of clinical MPD that the disorder is artifactual. In fact there is not one case of MPD created artifactually by a specialist in dissociation reported in the literature. Given the absence of positive evidence for the artifactual nature of clinical MPD, the data in the present study provide compelling evidence that MPD is a genuine disorder with a consistent set of core features. ■

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