DIAGNOSIS AND CLINICAL PHENOMENOLOGY OF MULTIPLE PERSONALITY DISORDER: A NORTH AMERICAN PERSPECTIVE

Frank W. Putnam, M.D.

Frank W. Putnam, M.D., is Chief of the Unit on Dissociative Disorders at the Laboratory of Developmental Psychology, National Institute of Mental Health, in Bethesda, Maryland.

For reprints write Frank W. Putnam, M.D., Room 105, Building 15K, National Institute of Mental Health, 9000 Rockville Pike, Bethesda, MD 20892.

INTRODUCTION

This paper presents an overview of the syndrome of multiple personality disorder (MPD) as it is currently conceptualized in North America. The paper begins with a review of North American definitions of dissociation and MPD. A brief history of MPD in North America is followed by a review of the clinical phenomenology of these patients. Dissociative symptoms that characterize the syndrome are considered in detail. The manner in which the diagnosis is made is discussed. The paper concludes with an examination of some of the issues and problems with the current North American model of MPD.

Definitions of Dissociation and Multiple Personality Disorder

A review of the definitions of dissociation advanced in North American psychiatry indicates that dissociation is conceptualized in two basic ways. In the first set of definitions, dissociation is viewed as a psychophysiological process occurring on a continuum that produces a disturbance in the integration of information and identity (Putnam, 1991a). The dissociative continuum is generally regarded as ranging from minor or "normal" forms of dissociation, such as daydreaming, to extreme pathological forms such as multiple personality disorder.

The second set of definitions conceptualizes dissociation as a special state of consciousness in which information and events that would ordinarily or logically be associated are divided from one another (Spiegel, 1991). Clinical features that distinguish a dissociative state from other states of consciousness include significant alterations in the person's sense of identity and behavior, and alterations in his cognitive processing of information. These cognitive alter-ations involve perception, logical operations, modulation of affect, and access to memory, knowledge and skills acquired by the individual. Alter personalities in multiple personality disorder and secondary identities in fugue victims are two examples of discrete dissociative states of consciousness.

These different conceptualizations are not mutually exclusive. Both formulations stress the division or disconnection of information that would normally be connected or integrated. It has been suggested that these two definitions can be reconciled by conceptualizing the dissociative continuum as the frequency and durations with which individuals enter into and sustain dissociative states of consciousness. Despite the uncertainty in definition, the measurement of dissociation has been successfully operationalized in a series of scales and interviews that quantify life experiences produced by impairments in the integration of information and identity (Bernstein & Putnam, 1986; Ross et al., 1989; Steinberg, Rounsaville, & Cicchetti, 1990). This situation may be analogized to the problem of intelligence, which is difficult to define, but is nonetheless frequently measured.

In North America, multiple personality disorder is conceptualized as a dissociative disorder in which executive control of the individual's behavior is exchanged among a set of dissociative alter personality states. It is regarded as the most extreme form of dissociation lying at the far pathological end of the dissociative continuum. In multiple personality disorder, the individual is psychologically organized as a set of discrete behaviorally different states of consciousness with different senses of self and different access to information and memory.

Benjamin Rush, often called the father of American psychiatry, was the first American physician to write about dissociation and multiple personality disorder. Notes from his 1811 medical school lectures indicate that he presented three cases of dissociation including one case of multiple personality disorder (Carlson, 1984). However, the contemporary case of Mary Reynolds, first published in 1816 by S.L. Mitchill, was more widely known (Mitchill, 1816). Subsequently described by other other authors many times during the following century, Mary Reynolds served as the classic example of MPD and under the label of *la Dame de Macnish* was cited in turn by Pierre Janet, Alfred Binet, and Carl Jung (Carlson, 1984).

At the beginning of the Twentieth century, Sally Beauchamp, a patient of Morton Prince, replaced Mary Reynolds as the clinical standard against which all other American cases were compared. Prince, a prominent Boston psychiatrist and founder of the *Journal of Abnormal Psychology*,

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published accounts of her treatment (Prince, 1906; Rosenzweig, 1988). Together with William James, the great psychologist, Prince introduced America to Pierre Janet's ideas on dissociation. Morton Prince was roundly attacked, however, by colleagues who suspected that he iatrogenically induced the alter personalities by hypnosis and suggestion. These allegations, together with the introduction to America of the new and, at that time, very broadly defined diagnosis of schizophrenia, led to a dramatic decline in the number of reported MPD cases over the next half century (Rosenbaum, 1980).

Isolated cases of multiple personality continued to be reported in North America during the ensuing decades (e.g., the case of Bernice R [Hacking, 1991]), but it was the popularized cases of *The Three Cases of Eve* and *Sybil* that attracted the most attention (Putnam, 1989). Cornelia Wilbur, Sybil's psychiatrist, played an important role in the adoption of the diagnosis of MPD in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)*. This official sanction led to a wider acceptance of the condition during the 1980s. Although still actively disputed by some, MPD and related dissociative disorders are currently the focus of much interest by North American clinicians working with victims of childhood abuse and trauma.

CLINICAL PHENOMENOLOGY AND DIAGNOSIS OF MULTIPLE PERSONALITY DISORDER

Clinical Presentations

North American proponents argue that MPD is more common than is generally thought and that it is often mistaken for another disorder, usually depression or borderline personality disorder. Several studies show that North American MPD patients average 6-7 years of involvement with the mental health system and typically acquire 3-4 psychiatric diagnoses before they receive a diagnosis of MPD (Coons, Bowman, & Milstein, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989; Schultz, Braun, & Kluft, 1989). In addition to acquiring a number of psychiatric diagnoses, MPD patients have history of repeated treatment failure.

Clinical presentations are quite varied ranging from florid decompensations with overt alter personalities struggling for control of the individual's behavior to covert presentations in which there is no overt evidence of alter personalities or amnesic symptoms. Florid overt personalities are relatively rare, however, accounting for less than 25% of diagnosed cases (Kluft, 1991a; Kluft, 1991b). In many instances, patients are in treatment with a therapist for several years before MPD is suspected (Putnam et al., 1986).

The most common clinical presentation is that of an atypical, treatment-refractory depression, usually accompanied by a plethora of anxiety and somatic symptoms (Coons et al., 1988; Putnam et al., 1986; Ross et al., 1989; Schultz et al., 1989). The patient may report extreme lability of mood with frequent periods of short-lived depression. Depressive vegetative signs, such as loss of appetite, weight loss, decline in sexual function, and lowered energy level are usually absent. The individual may report significant problems with sleep.

A carefully taken history will find that the sleep disturbances include traumatic nightmares, sleep terrors, difficulty falling asleep, and fear of returning to sleep after awakening. These sleep problems resemble the sleep disturbances found in post-traumatic stress disorder (PTSD). A history of suicide attempts is reported in about 80% of cases or about two times more often than in major depression (Coons et al., 1988; Putnam et al., 1986; Ross et al., 1989; Schultz et al., 1989). Self-mutilation, done secretly, is common.

Somatic symptoms are common (Coons et al., 1988; Putnam et al., 1986; Ross et al., 1989; Schultz et al., 1989). A history of migraine-like headaches is seen in the majority of cases, often leading to neurological evaluations and treatment. Epilepsy is diagnosed or considered in a substantial number of cases, but despite a high rate of non-specific electroencephalitic (EEG) abnormalities, most seizure-like behavior is psychological in origin (Devinsky, Putnam, Grafman, Bromfield, & Theodore, 1989). Gastrointestinal symptoms, particularly functional bowel disease, are seen in many cases. A growing literature is connecting psychosomatic problems with histories of childhood abuse, a common historical finding in MPD patients (Loewenstein, 1990). Unexplained pain, usually abdominal or pelvic, is also quite common. In most instances, no organic cause can be found that accounts for the patient's physical symptoms.

Social History

Most studies of North American MPD patients published to date find an overwhelming predominance of female cases. This can be partially explained by (1) the much higher rates of females in North American mental health treatment, particularly outpatient treatment; and (2) the propensity of male MPD patients to be found in drug or alcohol treatment or criminal justice programs not sampled in research studies (Loewenstein & Putnam, 1990). Females are also believed to be at greater risk for sexual abuse than are males, though some have questioned this assertion.

As the disorder often does not become disabling until the third or fourth decade of life, MPD patients, as a group, are generally better educated than are most chronic mental patients. They typically have a history of good occupational achievement that deteriorates prior to their clinical presentation. Many continue to hold responsible jobs and to function well at work despite profound dysfunction in other life areas. MPD patients have serious problems maintaining stable relationships, and marital problems and divorce are common.

Childhood History

One of the major tenets of the North American model of MPD is that it is caused by severe, repetitive abuse in early childhood. This belief is based on a series of studies that uniformly found high rates of childhood trauma in adult MPD patients (Bliss, 1986; Coons et al., 1988; Hornstein & Putnam, 1992; Loewenstein & Putnam, 1990; Putnam et al., 1986; Ross et al., 1991; Schultz et al., 1989). In general it appears as if the abuse and trauma experienced by MPD patients occurs earlier in childhood than for non-MPD patients. Research with child MPD patients compared to non-MPD

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child sexual abuse victims finds significant differences in ages of onset (Putnam, Helmers, & Trickett, 1993). It is also believed that the trauma experienced by MPD patients is on average more severe than is the abuse experienced by non-MPD childhood abuse and trauma victims. Although clinically this often appears to be the case, this hypothesis has not yet been proven. Research with child and adolescent cases of MPD in whom actual legal documentation of reported trauma is often possible, has largely confirmed the findings reported for adult samples (Dell & Eisenhower, 1990; Hornstein & Putnam, 1992; Hornstein & Tyson, 1991). However, the factors that lead to the development of MPD as opposed to other outcomes still remain to be conclusively delineated.

Dissociative Symptoms

For a variety of reasons, North American MPD patients often do not report their dissociative symptoms on initial contact with psychiatrists. These symptoms must be uncovered through a careful clinical inquiry. For purposes of this paper, dissociative symptoms are conceptualized as belonging to four categories: (1) amnesias and memory disturbances; (2) dissociative process symptoms; (3) depersonalization/derealization symptoms and (4) trance-like phenomena. As part of a routine clinical evaluation, questions probing these four dissociative symptom groups can be interspersed among other standard inquiries.

Amnesias and Memory Disturbances

A variety of amnesic experiences are reported by MPD patients. They frequently describe gaps in the continuity of time, referred to as "blackout spells" or "losing time." In many instances, the patient finds evidence that he or she has continued to function normally but has no recollection of the events. Fugues are common and usually involve prosaic activities rather than dramatic escapades. The individual often discovers that he or she has possessions for which he or she can not account. In women this most often involves clothing, jewelry or cosmetics. Men discover unexplained tools, gadgets, and weapons. Other perplexing experiences involve inexplicable changes in relationships, e.g., someone is angry with the patient and he or she has no understanding of why.

MPD patients often admit to difficulties in remembering information that they know that they know, e.g., how to operate a familiar piece of machinery or where a good friend lives. At times they have great difficulty accessing basic knowledge or well-learned skills such as the multiplication tables or how to drive an automobile. These difficulties in recalling well-learned information are inconsistent and unpredictable, i.e., on many occasions they can perform the task well but on some occasions their mind goes "blank." Recent laboratory research supports these clinical observations and suggests that these memory difficulties are most apparent for the "implicit" memory system. The implicit memory system mediates storage and retrieval of information that is recalled without recalling the context in which the information was learned (Putnam, 1991b). Other memory functions and systems are involved in MPD, however, and further research is needed to clarify our understanding of how dissociation affects storage and retrieval of information (Nissen, Ross, Willingham, MacKenzie, & Schachter, 1988; Schachter, Kihlstrom, Kihlstrom, & Berren, 1989; Silberman, Putnam, Weingartner, Braun, & Post, 1985).

MPD patients often have great difficulty recalling autobiographical information (Putnam, 1989; Schachter et al., 1989). Although they may intellectually "know" the content of the information in question, e.g., the date and place of their marriage, they do not remember actually being there and what they said and did. Extensive amnesias for childhood memories are especially common and take the form of sharply demarcated gaps in the chronological continuity of childhood, e.g., reporting an inability to recall any memories from ages 12 to 14 years with intact recall for prior and later events. Childhood amnesias may be discovered by systematically inquiring about each school year.

Finally, MPD patients have difficulty in determining whether or not memories reflect events that actually happened to them. Many of their memories have a depersonalized quality so that they are recalled as if they involved someone else. MPD patients report being confused about whether they actually did something, e.g., mailed a letter, or merely thought about doing it. They may also have difficulties in differentiating information acquired through direct personal experience from information learned from other sources, e.g., reading it in a book. These amnesias for the source of their information and the gaps in the recall of their personal histories caused by autobiographical amnesias make MPD patients vulnerable to mistakenly incorporating information from other sources into their own life story.

Dissociative Process Symptoms

Dissociative process symptoms reflect the interactions of the alter personality states. Auditory hallucinations are very common, although until a therapeutic alliance has developed patients will delay reporting these experiences for fear of being considered psychotic. MPD auditory hallucinations differ from those typically reported in schizophrenic patients in that they are experienced as coming from within the head and involve distinctly heard voices with attributes such as age, gender, and race. Specific voices may berate the patient while others provide advice or comfort. Voices may argue with each other or comment on the patient's behavior in the third person, e.g., "Jane [the patient's name] is not doing very well today." These internal voices reflect dissociative process interactions among alter personality states.

In addition to auditory hallucinations, experiences of being "made" to do or feel something against the patient's will are frequent. In the past, such passive influence experiences were equated with schizophrenia, but several recent studies indicate that they are significantly more common in MPD patients than in other diagnoses (Fink, 1991; Kluft, 1987; Ross et al., 1990). In some instances, the patient may feel controlled or "possessed" by an alien power and mistakenly diagnosed as having paranoid delusions. Clinically,

passive influence experiences are conceptualized as intrusions by one alter personality state into another, though how this occurs is not understood.

Switching symptoms refer to the psychological and physiological changes that occur when one personality state exchanges behavioral control with another alter personality state. Most exchanges of personality state are completed within five minutes (Putnam, 1988). Typical switches are accompanied by observable shifts in the patient's behavior, thought processes, speech, affect, and mannerisms. Clinically they may be detected by discontinuities in the train of thought and by amnesias for material preceding the switch.

In times of crisis, MPD patients may experience uncontrolled rapid switching with resultant lability of affect and fragmentation of speech, thought content, and behavior. Such rapid switching crises can easily be mistaken for a psychotic decompensation, but there is usually a very rapid resolution when the stress is terminated. Although MPD patients may transiently appear psychotic they do not have a persistent thought disorder. MPD patients usually have a full range of affect and are capable of good interpersonal relatedness, though they have difficulties with interpersonal social boundaries.

Depersonalization Symptoms

Chronic symptoms of depersonalization and derealization are common in MPD patients. Depersonalization symptoms include intense feelings of estrangement from self, often to the point of experiencing a non-being of self. Suicide attempts and episodes of self-mutilation are often associated with profound feelings of detachment from self and situation. During these episodes, MPD patients describe feeling as if they are disinterested observers of their own self-destructive behavior. Also common are out-of-body experiences, in which the patient reports feeling as if he or she is physically outside of him or herself and is watching his or her own behavior as if he or she were watching a movie. Related symptoms include automatization, in which the individual feels as if he or she functions like a machine or a robot and emotional numbing, in which the patient feels devoid of all emotion.

Chronic derealization, in which the individual experiences his or her environment as strange or unreal, usually accompanies depersonalization. Frequently the patient reports visual and auditory perceptual distortions such as the world appearing as if it were viewed through fog or smoke. Voices and sounds may be muffled or seem to come from far away. The MPD patient may feel as if he or she is physically separated from others by an invisible or glass barrier.

Trance Symptoms

From the time of Janet onward, the similarities between hypnosis and clinical dissociation were considered important to understanding the nature of MPD. Trance symptoms include a set of symptoms that are similar to phenomena that can be produced in highly hypnotizable individuals with hypnotic suggestion. Spontaneous age regression, often taking the form of the emergence of a "child" alter personality state, is common in MPD patients. Research with normal subjects suggests that at least two forms of hypnotic age-regression occur (Hilgard, 1986). MPD patients, and many PTSD patients, report an ability to voluntarily induce analgesia or anesthesia in parts of their body. This self-analgesic capacity is well-documented in highly hypnotizable normal individuals (Hilgard, 1986). The ability to block out pain is also seen in religious "dissociative states" in some cultures, and is regarded as one of the protective functions of dissociation in the face of acute trauma (Putnam, 1991a).

A marked upward rolling of the eyes into the head is often reported in descriptions of the signs and behaviors observed in MPD patients switching from one alter personality state to another (Putnam 1988). Prominent eyerolls have been documented with EEG studies of switching in MPD subjects. Several authors have suggested that the upward rolling of the eyes during a switch is similar to that seen in some hypnotic induction procedures, particularly those introduced by H. Spiegel (Spiegel & Spiegel, 1978). MPD patients may enter "trance-like" states in which they are unresponsive to external stimuli. These trance states, which may have a catatonic quality, are usually associated with stress or crisis, but can occur spontaneously.

The Alter Personality States

Although the alter personality states are considered to be dissociative process symptoms, they are discussed separately here because of their centrality to MPD. Disturbances in the integration of self are common in victims of trauma, especially in people suffering childhood abuse and neglect (Cole & Putnam, 1992). In MPD, the individual is psychologically organized as a set of distinct identities that exchange control over behavior. Most North American MPD experts do not believe that the alter personality states represent separate or complete personalities or people. Rather the alters are viewed as relatively stable psychological structures which serve to encode sets of behaviors, affects, and memories. Unfortunately, the popular press and media misrepresent these entities as separate and complete individuals. This exaggeration of separateness generates erroneous expectations that complicate the diagnosis and treatment of these patients.

Very little is really known about the alter personalities and what they truly represent (Putnam, 1992). Recent studies suggest that the typical patient has between three and twenty of these entities. The numbers of alters reported in recent cases appears to be increasing, a trend that bears critical examination (Hacking, 1991; Putnam, 1989). Only a few studies have catalogued some basic types of alter personalities that seem to be common to many patients (Alpher, 1992; Putnam, 1989; Ross, 1989). Commonly reported types include: (1) child alters, which are age-regressed variations of the individual and frequently encode traumatic childhood memories; (2) alter personalities that report themselves to be of the opposite gender from the patient's biological gender; and (3) persecutory alters, which assault the patient physically and psychologically for a variety of psychodynamic reasons (Alpher, 1992).

Preliminary physiological and psychological research with

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the alter personality states suggests that they are separable and distinct in some domains and linked in others (Putnam, 1991b). The amnesias that exist between pairs of alter personality states involve certain types of information (e.g., emotionally charged memories) more than other types of information (Putnam, 1991b). Often ignored by those seeking to emphasize the distinctness of the alter personality states are data indicating that for some physiological measures, e.g., habituation to a noxious stimulus, there is essentially complete carry-over of information from one alter personality state to another (Putnam, Zahn, & Post, 1990). In general, the degree of physiological and psychological separation between alter personality states is of the same order of magnitude as the differences observed between affective states in bipolar illness or behavioral states in periodic catatonia.

MAKING THE DIAGNOSIS OF MPD

The diagnosis of MPD is primarily based on clinical and historical data. There are no definitive psychological or laboratory tests for MPD, though high scores on the DES and specific profiles on certain psychological tests support the diagnosis (Armstrong, 1991; Armstrong & Loewenstein, 1990; Carlson, Putnam et al., 1993). In many cases, the clinician develops a growing suspicion over time that the patient may have a dissociative disorder. This suspicion usually arises out of perplexing interactions with the patient, for example, the patient denying that he or she attended a treatment session that did take place or the patient manifesting very different styles of behavior and relatedness from session to session.

It is recommended that therapists who suspect MPD proceed to carefully document dissociative symptoms and experiences in their patient before attempting to elicit alter personality states. The clinician should ask questions that probe the dissociative experiences and symptoms described above. When the patient acknowledges having dissociative symptoms or experiences, the clinician should ask for specific examples that can be examined in detail. If the examples are convincingly positive, the therapist should inquire if the patient has ever felt as if there were other parts or sides to him or her. At this point, some MPD patients may acknowledge the existence of alter personalities, while others may only report a vague sense of another part that feels alien or in conflict with the patient's feelings, values, and wishes. It may be necessary to address this question a number of times with the patient.

If the therapist hears sufficient material from that patient that suggests the presence of a dissociated personality state that assumes executive control from time to time, the therapist should seek to meet and interact with this part. Usually this can be done by directly asking to meet with the other "side" or "part" of the patient. Hypnosis is generally not necessary for diagnosis. If the patient has given the other "part" a name, descriptive attributes or has implicated the other part in unremembered behavior, this can be used to ask for the other "part." For example, "I would like to speak with the part of you that attended our last session which you do not remember."

The emergence of an alter personality state in response to such inquiries is a disquieting experience that frequently leaves the clinician wondering whether this is a real entity or one created in response to the therapist's expectations. If the alter personality state is real, it, together with other alter personality states, will have played a tangible role in the patient's life. The alter personality state will also be relatively stable and enduring across repeated appearances and will play an understandable role in the patient's symptoms and current life problems. As previously described, it is an error to treat an alter personality state if it were a separate and independent entity apart from the patient. In the North American formulation of MPD, "the patient" is regarded as the total collection of alter personality states.

ISSUES AND PROBLEMS WITH THE CURRENT NORTH AMERICAN FORMULATION OF MPD

To understand the phenomenon of multiple personality disorder in North America, one must take into account the context in which it has reappeared on the psychiatric scene. The reawakened North American interest in MPD comes not from academic centers and established psychiatry and psychology, but from clinicians working in primary care clinical settings. In the United States and Canada, primary care mental health services are provided by a heterogeneous group of clinicians including psychiatrists, psychologists, social workers, psychiatric nurses, and a variety of individual, family, and marital counselors. As a group, MPD therapists come from very different backgrounds and often do not speak the same clinical language.

Although this diverse collection of mental health professionals and paraprofessionals has found some common ground around the clinical issues of child abuse and MPD, there are a number of consequences of their alliance. The first is that the level of professional discourse remains at a basic level in order to facilitate communication. This impedes a more sophisticated examination of MPD. Clinical ideas, theories, and data are not critically challenged in the same fashion that they would be if they were put forward within a single discipline that shared an established tradition of debate and review. The North American MPD literature, which is very uneven in quality, reflects the heterogeneity of clinical and theoretical perspectives brought to bear on this syndrome.

Secondly, the educational process currently training therapists to treat MPD patients does not originate within an established clinical tradition. Training in psychotherapy requires ongoing case supervision and continuing case conferences. At present, MPD therapist education is largely conducted through a recently instituted educational system designed to provide therapists with the updated information necessary to retain their professional licensure. This system, known as Continuing Medical Education (CME), is largely unregulated and caters to popular interests in order to attract paying participants. CME courses and workshops are short, usually only one or two days in length, and typically offer no clinical supervision or direct patient contact. CME students do not receive supervision or critical feedback from their teachers. Fortunately, this situation is changing as estab-

lished clinical programs incorporate training in the dissociative disorders into their curricula.

The *DSM-III-R* and *DSM-IV* criteria for MPD are ambiguous and broad, which has worked against the acceptance of the diagnosis in some circles. At the time that these criteria were written, the intention was to facilitate the diagnosis of MPD, which was believed to be under-recognized. Unfortunately, the lack of precision has resulted in the misdiagnosis of MPD in some cases. Recent corrective efforts to increase the specificity of the *DSM-IV* criteria were only partially successful. A number of research studies now use the National Institute of Mental Health (NIMH) research diagnostic criteria. The NIMH criteria specify that in addition to meeting *DSM-III-R* criteria the diagnosing clinician must: (1) witness a switch between two alter personality states; (2) must meet a given alter personality on at least three separate occasions to assess the degree of uniqueness and stability of the alter personality state; and (3) must establish that the patient has amnesias, either by witnessing amnesic behavior or by the patient's report.

The question of iatrogenesis is often raised by critics of MPD. This concern, dating to the end of the Nineteenth Century, has never been satisfactorily resolved. Critics believe that these patients are highly suggestible and that alter personalities can be produced by simply asking about the existence of other parts or sides to the patient. Studies by Spanos and his colleagues (Spanos, 1986), alleging to produce MPD through experimenter demand effects have been criticized as lacking any clinical validity (Putnam, 1991a). The college students in the Spanos experiments have none of the pathological features of MPD; nor do they exhibit separate and distinct alter personality states. At present there is no convincing evidence that the full clinical syndrome associated with MPD can be iatrogenically produced. However, MPD patients do have heightened suggestibility in some areas and symptom fads have appeared and spread among patients following attention in the popular media. The memory disturbances experienced by these patients, particularly their difficulties in determining whether their mental images and memories represent actual memories or were acquired from other sources, makes MPD patients potentially vulnerable to suggestion, contagion, and contamination effects. The failure of North American MPD therapists to acknowledge this problem has cost them credibility.

The questions of iatrogenesis and suggestibility have again been thrust upon the North American MPD therapist community in the form of allegations by some MPD patients that they are the victims of abuse involving sexual torture, human sacrifice, and cannibalism by international religious cults worshipping Satan. These allegations, which have also been made by non-MPD patients, are based on memories recovered in the context of psychotherapy. Despite almost a decade of sensational allegations, no independent evidence has emerged to corroborate these claims (Putnam, 1991c). Sharp disagreement about the reality of these allegations is dividing the North American MPD and sexual abuse treatment community. This question is triggering an emotional debate that pits the public data of memory researchers studying the falsification of memory against the private data of clinicians conducting psychotherapy with such patients. Although this issue does not directly challenge the validity of the diagnosis of MPD, it does raise related issues of possible iatrogenesis in the psychotherapy of patients reporting childhood abuse. Until a satisfactory resolution of these allegations is achieved, the credibility of MPD patients and sexual abuse victims in general will be increasingly challenged. ∎

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