BACKSTAGE IN PSYCHIATRY: THE MULTIPLE PERSONALITY DISORDER CONTROVERSY

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ABSTRACT

Helping professions like psychiatry have traditionally granted their members a wide latitude in diagnosing clients. However, the diagnostic system may be the occasion for professional conflict. Arguments about the existence of Multiple Personality Disorder (MPD) are examples of such a professional dispute. Some mental health professionals report unprofessional conduct both toward professionals making this diagnosis and their patients. Skepticism is manifested in literary as well as behavioral forms. The most widely cited recent skeptical paper is Harold Merskey's (1992) "The Manufacture of Personalities: The Production of Multiple Personality Disorder." Merskey utilizes arguments that are sociological in nature but with little attention to empirical evidence. Merskey's skepticism about MPD differs from skepticism in natural science. Proponents' research is ignored rather than being subjected to critical examination and disproof through attempted replication. His skepticism appears largely based on challenges to the integrity of MPD patients and questions about the competence of therapist.

INTRODUCTION

The sociology of professional disputes falls somewhere in between the sociology of knowledge and the sociology of professions. Because professional disputes are doubly marginal, they tend to be ignored in sociological literature.

Bruno Latour (1987) has pointed to the role of controversy in shaping science. Latour's primary emphasis is on rhetoric. He argues that scientific texts are designed to withstand criticism and thus survive controversy. Statements in scientific texts are "black boxes" with which a critical reader must struggle in order to open up. References constitute another sort of black box. By referring to other papers the author forms alliances with their authors. These alliances isolate the reader. These literary tactics are designed to brunt and deflect criticism from the author's contentions. Latour's view of scientific disputes is largely limited to the formal,, written aspects of those disputes. But should professional conflict be viewed solely from a rhetorical perspective, or are other social forces at work which must be taken into account in investigating professional controversies?

Helping professions such as psychiatry traditionally have afforded their members wide latitude in typifying and treating clients. The system of typification within a profession would normally be expected to be a matter of professional consensus, but this is often not the case in psychiatry. Thus the existence and extent of the members of a diagnostic category in psychiatry can be an occasion for professional conflict.

Multiple Personality Disorder (MPD) is the subject of one such ongoing dispute in psychiatry and allied professions. This controversy has drawn increasing attention from psychologists, social scientists, and philosophers.

Skepticism about the existence of MPD can either be based on rational and scientific concerns, or it may reflect concerns that are not on the whole matters of science or rationality. Our present focus will be on the behavioral and rhetorical expressions of extreme skepticism about the existence of MPD, which appear to be neither rational or scientific.

BEHAVIORAL SKEPTICISM

Latour (1987) did not study behavioral aspects of scientific controversy. Goffman (1959) termed behavior which is not intended for public observation "backstage behavior." Dell (1988), who surveyed professionals treating MPD, reported examples of backstage behavior among psychiatrists. Ninety-two percent of the respondents had encountered skepticism from psychiatrists about the MPD diagnosis. Eighty-four percent reported that their worst encounter of skepticism was with psychiatrist. Among the psychiatrists responding to the survey, 32% reported encountering aggression against an (MPD) patient or (diagnosing) therapist by professional colleagues. Another 32% of the psychiatrists reported interference with MPD patients' treatment. These behaviors can be characterized as unethical and unprofessional conduct. Therapists reported:

> that inpatient medical directors banned them from the unit, attempted to refuse their admissions, and repeatedly scheduled staff meetings that challenged the admitting clinician's diagnosis, treatment plans, and discharge plans. Patients considered to be actively suicidal by the admitting clinician were discharged despite the admitting therapist's strong protest that the discharge was unsafe. Survey respondents said that nursing staffs

> had refused to follow their treatment plans, and that the medical directors had ordered their unit staff not to treat the patient as having MPD. Some respondents claimed that nursing staff were forbidden to attend lectures on MPD or to watch videotapes of the patient in dissociated states or alter personalities. Finally, many of the survey respondents stated that they had been demeaned and ridiculed both behind their backs and in front of patients and other professionals. (Dell, 1988, p. 530)

Not only have therapists been victims of unethical conduct:

> Many (MPD) patients were told that staff did not believe their therapist's diagnosis. Some patients were bluntly told that their therapists were "totally wrong." In a few cases patients were told that their therapist had "made" them multiple personality patients. Finally, many respondents reported that their patients had repeatedly encountered medical directors and inpatient staff who had berated them, called them "liars," tried to "prove" to them that they did not have MPD, and accused them of "manipulating," and of being "psychopaths," of being "a phony," and of having "made the whole thing up just to get attention." (Dell, 1988, p. 530).

Dell concluded, "Many of these incidents entail levels of skepticism about MPD that would seem to far exceed the boundaries of both professional conduct and good clinical care" (1988, p. 530). Such opposition goes far beyond matters of professional belief and disbelief. "Something very emotional (and very destructive) is happening here" (Dell, 1988, p. 530).

Sometimes the unprofessional attitude of an MPD skeptic finds its way into print. More surprisingly, once these attitudes find literary expression they are repeated by other critics. Skeptics Merskey (1992) and Aldridge-Morris (1989) cite a clinical psychologist, Victor, as a supportive authority in passing without hinting to the reader the nature of Victor's argument. In fact, Victor's "argument" was nothing more than a vicious and unprofessional attack on Cornelia Wilbur.

Victor (1975) responded to Dominick A. Barbara's review of *Sybil* in the *American Journal of Psychiatry*:

> The French have given us a still better diagnosis for this case — *folie à deux*. It is clear that the sixteen selves said to be inhabiting Sybil's body were as real to her psychoanalyst as to Sybil herself. In fact, most of the time Sybil refused to accept their existence, while the analyst believed in their reality, even claiming to see and speak with them.
>
> Thus one of the novelties in this case is that the analyst tried for years to believe in a complex delusional system...
>
> I would like to suggest the possibility of a diagnosis of multiple personality (or grand hysteria) being made is positively correlated with the romantic and fanciful tendencies of the diagnostician. (Victor, 1975, p. 202)

Victor's diagnosis of Wilbur resembles those of psychiatrists who told a 1964 survey for *Fact* magazine that Senator Barry Goldwater, the Republican Presidential candidate, was a paranoid schizophrenic (Szasz, 1970). Victor had not interviewed the subjects, nor utilized standard diagnostic procedures. His only grounds for describing Wilbur as psychotic was that he disagreed with her diagnoses and treatment procedures.

Professional misconduct toward patients and therapists treating MPD is by no means limited to American psychiatry. In 1992, Ian MacIlwain, a British therapist, wrote in *The British Journal of Psychiatry*:

> I have either personally interviewed, treated or been consulted about many other (MPD) cases both in urban Surrey and in Aberdeen... Many MPD patients have told me that they feared to reveal their condition to psychiatrists, sensing that they would be misunderstood and thought to be schizophrenic. Such is the skepticism of the psychiatric establishment regarding their condition, that their fear was perhaps not entirely misplaced... Professional ridicule and accusations of gullibility await those (therapists) who are foolish enough to declare an interest (in MPD) in public, or to seek to study this fascinating condition. (MacIlwain, 1992, p. 863)

MacIlwain reports censorship by British professional journals for case reports and other articles which express a favorable view of MPD. Wilbur and Torem (1993) reported that such censorship of papers related to MPD also existed in American psychiatric publications in the past. Reports of unprofessional conduct, informal sanctions and censorship suggest that the MPD controversy has a bitter and personal edge that was absent in Latour's (1987) account of scientific controversies.

LITERARY SKEPTICISM

Writing for professional journals constitutes frontstage as opposed to backstage behavior (Goffman, 1959). Critics of MPD must observe formal sets of rules in order to produce papers consistent with their beliefs. They assume that by following these rules, the product will qualify as scientific. Harold Merskey's (1992) "The Manufacture of Personalities: The Production of Multiple Personality Disorder," is an important expression of literary skepticism toward MPD. It was published in the highly prestigious *British Journal of Psychiatry*, a journal which usually devotes its pages to articles reporting quantitative research. Merskey reviewed the skeptical literature and set forth his own arguments for rejecting the exis-

tence of MPD. Within a year of its publication Merskey's article had been widely cited.

Many of Merskey's explanations for MPD could be described as sociological. Merskey focuses much of his argument on the effects of publicity for MPD on patient behavior. He also focuses on the effects of therapists' beliefs and treatment techniques on patient symptoms and behavior.

Merskey asserts: "The most dramatic examples of this syndrome (MPD) attract much attention, ranging from *The Three Faces of Eve* (Thigpen and Cleckley, 1957) to an unfortunate 27-year-old waitress in Oshkosh, Wisconsin, who claimed 46 different personalities, of whom six were sworn in and gave testimony in a trial. (Daniels, 1990). Publicity must be suspected of producing such events" (p. 327). A straightforward interpretation of this argument runs: if MPD causes publicity, then publicity causes MPD. This interpretation of a logical fallacy, as can be demonstrated by the parallel use of the form: "If floods cause publicity, then publicity must be suspected of causing floods."

INTERPRETING MERSKEY'S ARGUMENT AS A THESIS: PART I

Another interpretation of Merskey's statement is that it is not an argument at all, rather it is a thesis. Interpreting Merksey's statement as a thesis could lead to one of two meanings: (1) People believe that, or pretend that they have MPD for the sake of the attendant publicity. (2) Publicity about MPD causes people to believe or pretend that they have MPD.

If we accept interpretation (1), we can explore its validity by examining the cases Merskey cited, those of "Eve" and "the Oshkosh woman." In the former case, although it was well publicized, publicity can be discounted as an initial motive. When "Eve" first entered her psychiatrist's office, she had no idea that her case would be publicized. The publicity about her case was an unintended consequence of her treatment. In the case of the Oshkosh woman, we lack enough information to make a judgment. In addition to these two cases, there are thousands of people under treatment for MPD in the United States. Few will ever receive publicity for their case, and most have reasons to avoid publicity. They are often afraid of stigmatization within their communities. Therefore, a desire for personal publicity can be ruled out as a motive in most cases of MPD. Interpretation (1) must be rejected as unsupported by the cited cases and not credible in most others.

INTERPRETING MERSKEY'S ARGUMENT AS A THESIS: PART II

Interpretation (2) therefore is the only remaining explanation. Interpretation (2) has two possible forms. One form asserts a direct relationship between publicity or culture and patient identity and symptoms. The second form argues that MPD identity and behavior is the product of malingering. The direct form of interpretation (2) is "publicity about MPD causes people to believe that they have MPD." Let us consider a parallel example: "Publicity informs people about heart attack symptoms. People who are aware of heart attack symptoms are more likely to believe that they are having heart attacks. They are more likely to seek medical help."

No one would assert from this argument that publicity causes heart attacks. Many other parallels exist. For example, publicity about symptoms of cancer causes people to believe that they have cancer. Publicity about symptoms of depression causes people to believe that they are depressed. Publicity about symptoms of schizophrenia causes people to believe that they may have schizophrenia. Placed in this context, the statement, "publicity about MPD, causes people to believe that they have MPD," implies nothing about the validity of the MPD diagnosis. Thus Merskey must prove that MPD is categorically different from problems like heart conditions, cancer, schizophrenia and depression, and that this difference always leads to false positive diagnoses.

Much of Merskey's paper is devoted to exploring the cultural variants of the "publicity causes MPD" thesis. He argued that the idea of MPD originated in the misdiagnosis of patients' symptoms by 19th-century doctors. In this historical excursion Merskey attempts to traced the development of the ideology of MPD. Merskey recalls that Sybil read psychiatric case histories prior to the revelation to Cornelia Wilbur that she had MPD. Ideology, Merskey claims, influenced Sybil's behavior and Wilbur's diagnosis. This argument is central to Merskey's case, even though he gives Sybil relatively little attention, because of the publicity which the Sybil case generated for the concept of MPD. Over four million copies of *Sybil* were sold in the 1970s, and millions more watched the popular dramatization of the story on television.

There are several weak links in Merskey's argument. The relationship between historical cases and recent cases of mental illness is problematic. Even if patients and therapists know about historic cases, it does not follow that such knowledge alone can cause MPD symptoms, any more than reading about the history of cardiology can cause heart diseases. It often cannot be determined if a particular patient had knowledge about historical cases, or even if a patient had knowledge of historical cases, what if any effect that knowledge had on the patient's diagnosis.

Consider the following three scenarios: (1) Sybil, an unhappy young woman, reads the case records of multiples. She unconsciously identifies with their unhappiness and symptoms and encouraged by the idea of MPD and a cooperative therapist, simulates their behavior. She receives her therapist's attention and great publicity as a result. (Merskey's case) (2) Sybil, an unhappy young woman, reads psychiatric case histories, seeking to find an account of someone like herself. She finds similar cases in accounts of multiples. Encouraged by this discovery, she reveals her condition to her therapist. She receives successful therapy. (3) Sybil, an unhappy young woman, reads psychiatric case records. She does not encounter accounts of multiples. Later she spontaneously reveals multiple personalities to her therapist. She receives successful therapy.

We have no factual basis for determining which of these three scenarios is accurate because we lack critical evidence.

Any choice among them would be speculative. If we cannot pick which scenario is most likely in a well-documented case such as Sybil's, it would be even less possible to do so for thousands of less well-documented cases. The argument that scenario (1) can account for MPD cannot be scientifically tested. It can be characterized as speculative, and must be weighed against patients' own accounts of why they sought treatment for MPD.

Scenario (1) is the least flattering to the MPD patient. This devaluation is consistent with the skeptics' approach, which regards MPD patients with undisguised disdain. Since Merskey has no scientific basis for scenario (1), his adherence to it can be accounted for by his pre-existing belief that MPD does not exist. He accounts for his belief that MPD does not exist by arguing that MPD patients simulate behavior they learn through the publicizing of MPD. This can be characterized as a circular argument or begging the question. Merskey holds a set of beliefs about MPD which refer for validation only to one another. Merskey (1992) himself observed, "it is reasonable to reject those diagnoses which most reflect individual choice...and personal convenience in problem-solving" (p. 329).

Malingering

A further form of interpretation (2) is "publicity about MPD causes people to pretend that they have MPD." Pretending to have a medical or psychological condition is called malingering by doctors. The argument for MPD as a patient hoax rests on the undoubted fact that some people diagnosed as multiples have turned out to be malingerers. Some of those cases, such as that of the Hillside Strangler Kenneth Bianchi, and the Colorado case of Ross Michael Carlson, have involved murderers who simulated MPD in order to create an insanity defense or to avoid trial on the grounds of incompetence. Some of those cases, such as that of the Hillside Strangler (Kenneth Bianchi) and the Colorado case of Ross Michael Carlson, have involved murders who may have simulated MPD in order to create an insanity defense or to avoid trial on the ground of incompetence, (Orne, Dinges, & Orne, 1984; Allison, 1984; Weissberg, 1992). Even in the case of Bianchi, not all authorities agreed with the malingering diagnosis (Watkins, 1984). It is not uncommon for murder defendants facing the death penalty to use insanity defenses, and MPD is hardly the only form of insanity that can be simulated. Psychopaths who are not legally insane frequently role-play psychotic behavior in order to establish a criminal defense.

Critics of the MPD concept such as Aldridge-Morris (1989) have chosen the Bianchi case as peridigmnatic for MPD as a whole. Spanos, Weekes and Bertrand (1985) based much of their research on a hypothesis derived from the Bianchi case. But Bianchi was hardly the typical MPD patient, and charges of widespread patient malingering require more proof than arguments derived from one or two atypical cases.

No evidence has been produced in support of the contention that most MPD cases involve patient fraud. Furthermore, since most MPD patients do not face criminal charges, their motive for simulating MPD is far from clear. If it is argued that the patient is faking MPD to get psychiatric attention, evidence suggests that most MPD patients were able to get psychiatric attention prior to their MPD diagnoses. The average multiple has been found to have been in the mental health care system for nearly seven years prior to the MPD diagnosis (Putnam, Guroff, Silberman, Barban, and Post, 1986; Ross, 1989). It might be argued that MPD is somehow a more desirable diagnosis within the mental health system, but this answer is based on the unproven assumption that patients get benefits from MPD diagnosis that they do not receive from other, presumably less glamorous, diagnoses.

The desirable diagnosis argument, however, is itself ambiguous. It could be that the primary benefit of a MPD diagnosis is that it brings to the patient better and more appropriate treatment. A proper diagnosis is one which leads to successful treatment. By this standard the MPD diagnosis has proven for many patients to be a proper diagnosis. If MPD diagnosis and treatment brings these patients to termination, while other forms of diagnosis and treatment do not, then the critic is faced with a daunting task should he or she attempts to establish the inappropriateness of the MPD diagnosis.

If the MPD patients were malingering, then their sole goal would have been to stay in treatment as long as secondary gains were possible. The success of MPD treatment suggests that this is not in fact happening. The argument that the thousands of MPD patients currently in treatment are faking fails for lack of evidence, and for manifest implausibility.

Iatrogenesis

In addition to his thesis that publicity about MPD is responsible for patient symptoms, Merskey also argues that therapists produce MPD-symptoms in patients. There are two possible sources of iatrogenic MPD: (1) The use of hypnosis, and (2) the shaping of MPD by the behavior and/or expectations of the therapist. MPD has historically been diagnosed and treated through the use of hypnosis. Merskey (1992) argues that the association of MPD and hypnosis is far from accidental. Researchers such as Spanos and his colleagues (1985) have reported that under hypnosis some characteristic symptoms of MPD can be simulated. But Braude (1991) commented: "The alleged personalities created hypnotically (in attempting to simulate the symptoms of MPD) differ in important respects from personalities occurring spontaneously. Not only are the former substantially lacking in depth and breadth, when compared to alters, they also have no life histories and no particular function in the emotional life of the patient" (p. 62).

Braude drew attention to the scientific inadequacy of the 1985 Spanos et al. study. In a laboratory setting, students role-played a scenario derived from the Bianchi case under hypnosis. Not surprisingly, many psychology student participants hit on the MPD ploy. But can a laboratory simulation of the Bianchi case demonstrate anything about MPD? If Bianchi was actually malingering Spanos' research really demonstrates that, given sufficient motivation, some people might attempt to simulate MPD. Braude (1991) comments

that using the Hillside Strangler as a paradigm of MPD is an example of "familiar and disreputable gambit of generalizing from the weakest case" (p. 63).

Not all MPD patients are hypnotized. The teachings of the Jehovah's Witnesses forbids hypnosis. Yet members of this religion have received the MPD diagnosis and are being treated for it. Ross and Norton (1989) have produced evidence which disconfirms the hypothesis that MPD is produced by hypnosis. They found that MPD patients who had never been hypnotized had similar symptoms to those who had been. Recent MPD diagnostic techniques utilize structured interviews, rather than hypnosis (Steinberg, 1993; Ross, Heber, Norton, Anderson, Anderson, & Barchet, 1989). The fulfilling of diagnostic criteria in these interviews is based on client's symptom histories. The argument that MPD is produced through the misuse of hypnosis cannot be supported by available evidence.

A further argument is that MPD is shaped by the therapist who consciously or unconsciously is leading the patient into pathological behavior patterns. Most of these arguments feature a variant of the hypnosis argument as well. Simpson (1988), cited by Merskey, adds a version of the therapist iatrogenesis argument. "Selective reenforcement of symptoms, unconscious or conscious, progressively shape the symptoms of and behavior of the patients, and the depiction of MPD is elaborated and reinforced" (p. 565). Simpson is suggesting that MPD is a match between a suggestible patient and a suggestible therapist. MPD is produced by the patient's desire to please the therapist, and thus is a manifestation of the power of the therapist over the patient. If Simpson's position is that only MPD advocates exert influence over patients' behavior, then this could be characterized as a localized antipsychiatry. It would entail that psychiatrists who diagnose and treat schizophrenia, or bipolar disorder, or any other "legitimate" psychiatric condition do not shape the clients' symptoms as MPD therapists are argued to do. But skeptics such as Freeland, Manchanda, Chiu, Sharma, and Merskey (1993) exerted social influence over patients' behavior by challenging the validity of the MPD diagnosis. In one case, the patient accommodated to the psychiatrist's position after he stated: "I don't altogether buy the idea of MPD." In another case the patient continued to believe that she had MPD despite her psychiatrist's objections. A third patient continued to report the existence of a second personality, even though she claimed to agree with her psychiatrist that she did not have MPD. The last case reported by Freeland et al. (1993) may have involved malingering, but the psychiatrist ignored the patient's reports of altered personalities. Thus case reports by skeptical psychiatrists demonstrate that they selectively reinforce symptoms and attempt to shape patient behavior. Dell (1988) reports that skeptical psychiatrists sometimes engage in coercive behavior to influence MPD patients to disavow their symptoms. The social influence argument must be evaluated for both the skeptics' as well as the proponents' case.

DISCUSSION

Skepticism about MPD could be classified as either backstage-behavioral skepticism or as frontstage-literary skepticism. Backstage skepticism includes a wide range of unprofessional conduct. It is backstage because psychiatrists and other mental health professionals do not with their unprofessional conduct to be viewed by an outside audience. Although literary skepticism avoids the crudity of backstage skepticism, its rationality is equally questionable. Published empirical studies have been based on questionable premises or have been so lacking in rigor as to be of no value. Neither the traditional Sociology of Science nor the Sociology of Discourse can adequately account for this phenomenon. Interpretations of the MPD controversy must look elsewhere for an explanation.

Although Merskey's arguments possess some frontstage qualities, there are similarities to the backstage unprofessionalism of Dell's skeptics. Merskey simply assumes that MPD does not exist. Therefore it must be the product of some social aberration: a culturally-created illusion, patient misconduct, or malpractice by therapist. Merskey appears to believe that his training as a psychiatrist qualifies him to engage in sociological speculation. Unlike professional sociologists, whose profession requires more than the mere expression of personal opinion to validate explanations, Merskey often offers his interpretations with little logic and even less evidence. While the behavioral skepticism is characterized by unprofessional conduct, Merskey's literary skepticism is characterized by unscientific discourse. Like the behavioral skeptics, his ultimate argument is a largely unsubstantiated attack on the integrity of MPD clients and the competence of therapists.

If we compare the MPD controversy with controversies in natural science, we find that unlike skeptical natural scientists, MPD skeptics have failed to generate a significant body of scientific evidence in support of their case. Merskey fails to critically examine the research of the proponents of MPD, or offer alternative explanations for their findings. In contrast, the critics of research in the natural sciences attempt to replicate critical experiments. They offered plausible alternative accounts of anomalous findings by credulous researchers. Critics are thus able to cite scientific reasons for rejecting of notions such as cold fusion.

It is far from clear what would constitute a critical test for the existence of MPD. It is clear, however, that thousands of patients have received the MPD diagnosis, and researchers are conducting a vigorous program of scientific inquiry on them (Ross, 1989; Putnam, 1989). In contrast, skeptics like Merskey have neither offered systematic criticism of MPD research, nor examined MPD patients in a rigorous fashion. The skeptics have failed to produce a case that can withstand critical examination. Thus literary skepticism concerning MPD is just as irrational as the unprofessional conduct of the extreme behavioral skeptic. Similar unprofessional conduct and irrational discourse have also been observed in the developing controversy concerning "the false memories syndrome" (Barton, 1994).

CONCLUSION

Our examination of the MPD controversy has not demonstrated that MPD should be accepted as a psychiatric diagnosis. Rather it demonstrates that some skeptical psychiatrists and mental health professionals do not always conduct themselves in a professional manner, have dismissed the diagnosis without examination of relevant research, and have failed to produce scientific research or rigorously reasoned arguments in support of their position. We are clearly dealing with a social phenomenon that is foreign to Latour's (1987) model of scientific controversies. Indeed, it is doubtful that the case skeptics present against MPD could be described as scientific. The multiple personality disorder controversy has caught psychiatry backstage. ■

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