

IATROPHILIA AND IATROPHOBIA IN THE DIAGNOSIS AND TREATMENT OF MPD

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INTRODUCTION

Multiple personality disorder (MPD) was underdiagnosed to the point of near disappearance for most of this century, and continues to be missed or dismissed quite frequently today. Coons, Fine, Torem and Kluff discuss some of the major reasons for this elsewhere in this symposium. Resurgence of interest in MPD about 10 years ago brought with it the seeds of the opposite problem: overdiagnosis, or the tendency to find MPD where it is not. Coons and Torem elsewhere in this symposium provide succinct discussion of inadvertent and overly enthusiastic false-positive diagnosis. It is probably the case that therapist attitudes about iatrogenesis can play significant roles in both under- and overdiagnosis.

Inappropriate fears of inducing or exacerbating MPD with diagnostic procedures and therapeutic interventions — particularly hypnosis — can make the therapist hesitant to recognize or treat the condition. An alternative diagnosis may seem to the therapist to be a safer haven for both himself and the patient. Other dissociative disorders, PTSD, major depressive disorders with psychosis, bipolar disorder, schizophrenia, and borderline personality disorder can all present signs and symptoms of MPD, and all can coexist with MPD, but they will be diagnosed and MPD will not. Putnam, Loewenstein, Silberman, and Post (1984) propose that MPD is a superordinate diagnosis.

On the other hand, inappropriate enthusiasm to find and treat MPD, without enough regard for the possibilities of iatrogenic mischief, can place the therapist and his patient in unfortunate circumstances. The therapist who wants to find MPD may be able to cultivate an apparent pseudo-MPD in some instances — e.g. in the patient in whom a differential diagnosis of Dissociative Disorder Not Otherwise Specified

(DSM-III-R 300.15) was never considered. As pointed out by all the authors in this symposium, misdiagnosis and inappropriate therapy are less likely to occur when the therapist is well grounded in the etiology, phenomenology, diagnosis and differential diagnosis of MPD. Myths and reality regarding iatrogenesis also should be understood (Braun, 1984a, 1986, 1988a, 1988b; Braun & Sachs, 1985; Kluff, 1984, 1987; Putnam, 1989).

HYPNOSIS AND IATROPHOBIA

Putnam (1989) astutely points out that iatrogenesis and/or exacerbation are the most common concerns of therapists beginning to work with MPD patients. The concerns may be bolstered when apparently new alter personalities emerge during psychotherapy or hypnotherapy. The therapist will ponder the possibility that suggestion played a role. Personalities that were poorly defined in early stages of therapy may show greater strength and definition as therapy progresses. The experienced therapist may view this as a positive step toward eventual integration, but the inexperienced or poorly prepared therapist may be less sanguine and wonder if the strengthened alter is a product of exacerbation of the MPD condition.

"The most convincing evidence that alters are not being iatrogenically induced comes with time," Putnam writes, "Although new personalities may be created in therapy, the great majority will have a life history that predates therapy. This history, with sufficient documentation, will emerge as the therapist and patient reopen the past and make it clear. In the long run, the question of iatrogenesis becomes less urgent" (1989, p. 132). In this statement, an experienced MPD clinician and investigator erodes the myth that hypnosis can induce an alter personality that meets the criteria of DSM-III-R (1987) including an enduring pattern of perceiving, relating to and thinking about self and the environment. Braun (1984a) previously pointed out that a hypnotically-induced "other" may display some knowledge drawn from the patient's past, but cannot have true memory and individual life history with all of its affective and multiple sensory components.

Nonetheless, the myth of hypnotically induced MPD persists, perhaps drawing some potency from the demonstrably high hypnotizability of most MPD patients. The myth also has a long history. Braun (1984a) pointed out that the 19th Century French school of psychiatry, particularly Janet, linked hypnosis and hysteria in a theoretical construct, and regarded multiple personality as a form of hysteria. Thus,

hypnosis could be seen as a mechanism for inducing alters. The linkage of hysteria and multiple personality persisted well into our own time: DSM-II (1968) listed multiple personality under hysterical personality, dissociative type.

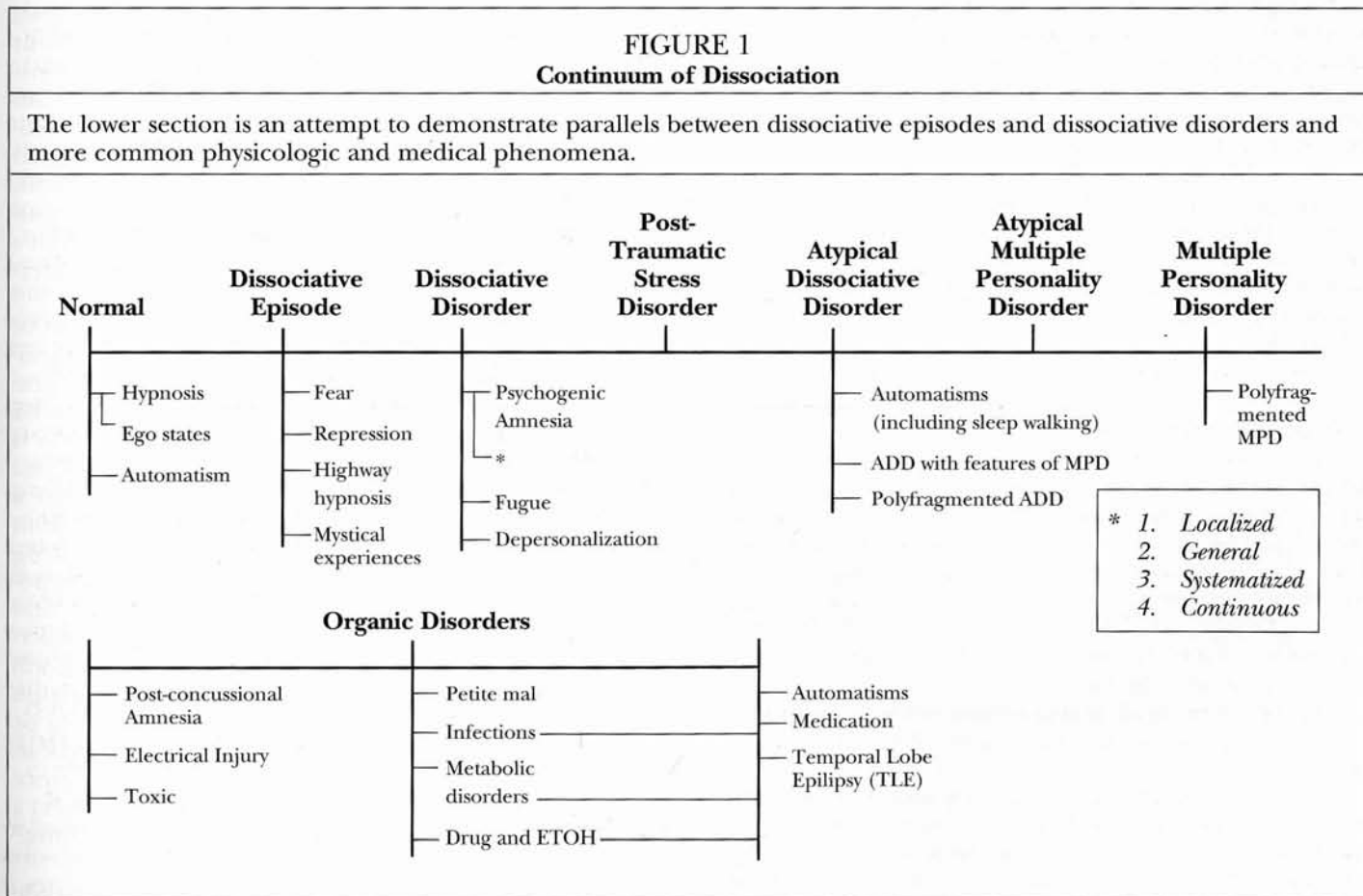
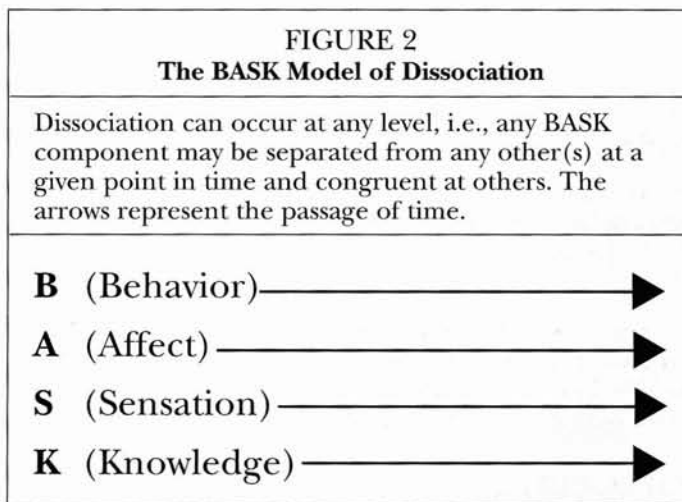
Investigators and clinicians who have treated MPD have noted repeatedly that MPD patients are excellent hypnotic subjects. Bernstein and Putnam (1986) demonstrated the MPD patient's capacity to dissociate by administering the Dissociative Experiences Scale to a variety of patients with and without mental illness. MPD patients had by far the highest DES score. Braun (1986) pointed out that the high hypnotizability — i.e. dissociative capacity — of MPD patients suggests that hypnotizability may be useful in the differential diagnosis of MPD.

DISSOCIATION AND THE ETIOLOGY/ PHENOMENOLOGY OF MPD

Hypnotizability, as a manifestation of the ability to dissociate, is not an indication that hypnosis can induce true alter personalities. The natural history of MPD belies the notion. Braun (1988a) showed how dissociation and the dissociative disorders can be graphically conceptualized on a Behavior-Affect-Sensation-Knowledge (BASK) model. On a graphic Continuum of Dissociation, hypnosis is shown at the far left, "normal" end of the continuum, and MPD is at

the "most dissociated" far right. If dissociation is defined as the separation of a thought process or idea from the main stream of consciousness, then "normal" dissociation can include heterohypnosis and automatisms, whereas "extreme" dissociation includes Dissociative Disorder NOS and MPD (Figure 1.)

The BASK model itself (Figure 2) indicates the four processes — Behavior, Affect, Sensation, Knowledge —



occurring over time (represented by the arrows). Dissociation of Affect and Sensation from Behavior and Knowledge occurs in hypnotic anesthesia. A break in the time continuum of all four processes over a period of time would be characteristic of psychogenic amnesia. MPD can be represented by shaded boxes labeled Personalities/Fragments A, B, C, etc., occurring across all BASK components at different points along the time continuum as they experience discrete and different BASK life histories. Because true memory requires at least the ASK portion of BASK — i.e., knowledge with affective and multiple-sensory components — the separate personalities can be said to have true life histories. A piece of hypnotically retrieved knowledge may be misinterpreted as the reporting by the patient of a "lost" life event, when in reality it is mere knowledge, not true memory.

In a literal sense, MPD is a condition wherein the "splitting" of life history among two or more personalities becomes a mechanism of psychic survival. The possibility that a full personality with life history, and at least the ASK portion of BASK memory, could be created by hypnosis is practically nil (Braun, 1984a.)

In nearly all MPD patients, the key to the development of the condition is a history of severe inconsistently administered abuse or neglect during childhood. Braun (1986) stated that the MPD patient will almost surely have a history of abuse as a child. Uncovering the history can be difficult, especially if, as is often the case, the abuse occurred in a family context and was regarded as a "secret." The patient may have been threatened with serious harm or death if the "secret" was revealed. Additionally, in later life, the adult MPD victim displays furtive behavior in order to cover up the "oddness" associated with disjunctive life histories in the same physical body.

The 3-P model of Braun and Sachs (1985) conceptualizes the abuse diathesis as predisposing, precipitating and perpetuating factors associated with the development of MPD:

1. Predisposing factors
 - a. an inborn biopsychological capacity to dissociate (usually identified by high hypnotizability.)
 - b. repeated exposure to an inconsistently stressful environment, such as abuse that occurs at the hands of parents or otherwise "loving" caregivers
2. Precipitating event
 - a. an overwhelming traumatic episode to which the victim responds by dissociating
 - b. usually a form of child abuse
3. Perpetuating phenomena
 - a. traumatic events linked by a common affective theme or neurophysiological state (Braun, 1984b), chaining the memories of each event in amnestically separate compartments.

Kluft's (1984) four-factor theory draws much the same conceptual picture of MPD's connection to abusive experiences. Both the 3-P and the four-factor theories show the MPD patient to be a person for whom the ability to dissociate is the gateway to escape from intolerable psychic stress. As

time goes on and other stressful life events impinge upon the victim, flight through the dissociation gateway can become a frequent escape route.

THE REALITIES OF IATROGENESIS IN DIAGNOSIS AND TREATMENT

The therapist who fears to diagnose or treat an MPD patient, perhaps because of "Iatrophobia," among other reasons, will probably refer the patient to another therapist or treatment center. Of greater concern may be the therapist who plunges into MPD diagnosis and treatment without adequate knowledge or experience. While the latter therapist may not fear iatrogenesis, he will probably be ill prepared to (a) differentiate MPD from other mental disorders, and (b) recognize the havoc that follows from misdiagnosis and poorly conducted therapy.

As indicated earlier in the paper, true MPD is characterized by the existence of alter personalities with discrete life histories, by secrets, and by an abuse history that almost always must be uncovered. Such entities cannot be induced by hypnosis or by other iatrogenic suggestion. However, as Kluft notes in his contribution to this symposium, many of the surface characteristics of MPD can be created quite readily, thus leading the expectant therapist to a misdiagnosis and wrongly directed therapy.

A first encounter with an apparent alter also can be misleading. This would be particularly true for the therapist who had some hope or expectancy to find an alter. A patient sensitive to the therapist's wishes can often make a convincing pseudo-MPD presentation. The malingering patient will purposefully set out to deceive the therapist with the presentation of one or more alters. The therapist is well advised to avoid "first-impression" commitment to an MPD diagnosis, and equally as important, to avoid signaling to the patient that multiple personality is a presumptive diagnosis. Kluft's excellent 1987 article on malingering MPD is a useful reference.

Braun (1986) observed that making the diagnosis of MPD is difficult. The therapist must document the consistency of MPD symptomatology over several different occasions. Only when the diagnosis is firmly made, it is shared with the patient when the therapist is confident that a trusting therapeutic relationship has been established. Trust does not come easily, Braun noted. The MPD patient has a "secret" history of childhood abuse, and is accustomed to dealing with authority figures who are perceived as being both rigid and unpredictable. The patient will try to manipulate the therapist throughout the course of diagnosis and treatment. The therapist must be aware of countertransference and not become aggressive or defensive. Patients will try to double-bind the therapist; e.g., to set up a situation where the therapist will appear to be either uncaring or abusive, no matter what course of action is taken. This, in turn, makes awareness of countertransference even more critical. A therapist could conceivably be tempted to reject a diagnosis of MPD at this point, and opt for a more "punitive" diagnosis.

After the diagnosis is shared, the therapeutic relation-

ship may be tested almost immediately by the patient's acting out in reaction to exposure of the "secret." Throughout the rest of the early and middle portions of treatment the therapist can expect a cyclical pattern of acceptance and rejection of the diagnosis. Kluft points out elsewhere in this symposium that the therapist may even see a "healthy" alter appear, either to deny the diagnosis or to convince the therapist that the integration has been achieved. The "healthy" alter could conceivably be called iatrogenic, insofar as it is a brief appearance by a special-purpose entity in response to therapeutic intervention. The entity almost surely would not qualify as a personality, by definition of life history and (B)ASK memory. Here the BASK model is useful in not only conceptualizing MPD, but in its psychotherapy as well (Braun, 1988b).

The overdiagnosis of MPD, or seeing MPD where it is not, can represent a failure of the therapist to use the critical definition of MPD in differential diagnosis. Non-dissociative disorders can present a problem for the therapist. Borderline personality disorder, which may exist to some degree in MPD patients, may prove a difficult differential diagnosis (Horevitz & Braun, 1984; Schultz, Braun, & Kluft, 1989). The other dissociative disorders may represent a special problem.

DSM-III-R (1987) lists five dissociative disorders, including MPD, psychogenic fugue, psychogenic amnesia, depersonalization disorder, and dissociative disorder not otherwise specified (NOS). In all of them the essential feature is a disturbance in consciousness, memory or self-identity. Any of the other dissociative disorders may be mistaken for MPD over greater or lesser periods of time. Psychogenic fugue or amnesia can manifest disturbances in consciousness, memory or identity, for example, but do not demonstrate repeated shifts in identity and are usually limited to a single episode.

Dissociative disorder NOS can pose a formidable problem in differential diagnosis, in particular when a therapist may be prepared to find MPD. Dissociative disorder NOS may be given too little consideration in differential diagnosis. Included under the dissociative disorders NOS classification are (a) Ganser's syndrome, (b) cases where more than one personality state takes executive control of the body, but none is distinct enough to meet the full MPD criteria, (c) trance states, (d) derealization unaccompanied by depersonalization, (e) dissociated states that occur after exposure to periods of prolonged and intense coercive persuasion, and (f) cases where organized and purposeful behavior and an inability to remember the past is not accompanied by the assumption of a new identity. Dissociative disorders NOS as well as other dissociative and non-dissociative disorders must be considered before a diagnosis of MPD is accepted, with or without any additional diagnosis.

SUMMARY AND CONCLUSION

Iatrogenic induction of an alter personality by hypnotic or other means is highly unlikely, given the DSM-III-R criteria for defining an alter. Fear of iatrogenesis may deter some therapists from making the diagnosis of MPD or

undertaking therapy. Overdiagnosis of MPD leads to finding MPD where it is not, or leading suggestible patients to induction of pseudo-MPD. Overdiagnosis also means that alternative or differential diagnoses such as dissociative disorder NOS do not receive adequate consideration. One should not fear the diagnosis of MPD or making the diagnosis of MPD. Education and consultation facilitate both making the diagnosis and carrying out the proper treatment of these patients. ■

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