Is Multiple Personality Disorder a Valid Diagnosis?


NO: Paul R. McHugh, from "Resolved: Multiple Personality Disorder Is an Individually and Socially Created Artifact," Journal of the American Academy of Child and Adolescent Psychiatry (July 1995)

ISSUE SUMMARY

YES: Psychiatrist Frank W. Putnam contends that the diagnosis of multiple personality disorder meets the standards for the three basic forms of validity: content validity, construct validity, and criterion-related validity.

NO: Psychiatrist Paul R. McHugh denies the validity of multiple personality disorder, asserting that this condition is a socially created behavioral disorder induced by psychotherapists.

Mental health experts have been fascinated for many years by the possibility that a person can develop seemingly independent personalities that are characterized by unique attributes and behaviors. For most of the past century, mental health experts used the label “multiple personality disorder” (MPD) to describe this kind of condition. During the past decade the official diagnostic term was changed to “dissociative identity disorder.” Regardless of which term is used, the essence of the condition is that an individual possesses two or more distinct personality states, each with an enduring pattern of perceiving, relating to, and thinking about the environment and the self. At least two of these identities recurrently take control of the person’s behavior, and the individual is unable to recall important personal information.

Relatively few cases of MPD were reported for most of the twentieth century, but that changed in 1980, when the authors of the Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. (DSM-III) included this condition in the list of mental disorders. The disorder was characterized as a condition in
which a person experiences a disorganization of the self that results in the experience of discrepant individuals residing within one’s overall being. Along with this broadening of the diagnosis came a proliferation of cases of MPD. Interestingly, in the years prior to 1970, only a handful of cases had been reported, but in recent decades many thousands of cases have been documented.

With the astronomical increase in the number of diagnosed cases of MPD, clinicians and researchers began to wonder if the increase was due to the increased incidence of the disorder or to an artificial phenomenon due to the broadening of the definition of the disorder. Some skeptics raised the worrisome possibility that the condition is iatrogenic—that it can be generated in a client by a psychotherapist, often through the use of hypnosis. Although presumably well meaning, the psychotherapist might suggest to a client that long-standing psychological problems are the result of a fragmentation of personality, thus leading the client to act and think in ways reflective of seemingly independent identities.

In the following selection, Frank W. Putnam contends that MPD is indeed a valid diagnosis, and he asserts that there are no documented cases in which the full syndrome of MPD was induced by fascination or by hypnosis. Further, he contends that MPD—and its core pathological process, dissociation—can be detected and measured by reliable and valid structured interviews and scales.

In the second selection, Paul R. McHugh contends that many individuals who develop the characteristics of MPD are responding to the crude suggestion of therapists that they harbor some “alter” personalities. Responding to the therapist’s suggestion, he concludes, the patient gets caught up in feeling pressured to act in ways that are consistent with the role of having several personalities.

**POINT**

- MPD is a valid diagnosis that meets the standards of the three basic forms of validity.
- The notion that MPD is iatrogenic is based on research with role-playing students in staged situations, which has little bearing on real-life clinical work.
- The clinical phenomenology of MPD has been delineated and replicated in numerous studies of more than 1,000 cases.

- MPD and its core pathological process, dissociation, can be detected and measured by reliable and valid structured interviews and scales.

**COUNTERPOINT**

- MPD is little more than a modern-day form of hysteria.
- MPD is a condition that is induced by therapists.

- Much of the expansion in the diagnosis of MPD is due to the fact that the condition is included in the DSM, which leads some practitioners to believe that MPD must exist because there are operational criteria available for making the diagnosis.
- Therapists elicit the expression of other personalities by presenting leading questions to the patient that reinforce the idea that the individual possesses separate personalities.
Response to Article by Paul R. McHugh

For more than a century, the existence of multiple personality disorder (MPD) has provoked heated debate. That both the diagnosis and the controversy are still with us says something about the resiliency of both sides of the question. The similarities between the charges leveled in the current debate and those in the historical record suggest that things, unfortunately, have not changed very much in 100 years. It is unlikely that this exchange will resolve the matter, but perhaps we can move the question along to a higher level. The criticisms leveled at MPD are not credible when examined in the light of what we know about the etiologies of mental illness. Debate can be advanced by critiquing the validity of MPD in the same manner in which the validity of other psychiatric diagnoses are assessed.

What are the criticisms of MPD? There are three basic criticisms made against this diagnosis. The first is that MPD is an iatrogenic disorder produced in patients by their psychiatrists. The second is that MPD is produced by its portrayal in the popular media. The third is that the numbers of MPD cases are increasing exponentially. The first and second charges are often lumped together and viewed as being responsible for the third.

The first accusation is historically the oldest and the most serious because it alleges therapeutic misconduct of the gravest nature. The psychiatrist's fascination with the patient's symptoms supposedly reinforces the behavior and produces the syndrome. A variation of this accusation charges that the condition is produced by the improper use of hypnosis. In either instance, the fact is that there are no cases reported in which the full clinical syndrome of MPD was induced either by fascination or by hypnosis. Experiments by Nicholas Spanos are sometimes cited as examples of the creation of MPD by role-playing students (Spanos, 1986). The reader is invited to compare the verbal responses of undergraduates responding to a staged situation with the psychiatric symptoms of MPD patients reported in the clinical literature. Two clinical studies examined the effects of using hypnosis on the symptoms and behaviors of MPD patients (Putnam et al., 1986; Ross, 1989). There were no significant differences between MPD cases diagnosed and treated with or without hypnosis. Since MPD appears in many patients with no history of hypnotic interventions, the misuse of hypnosis apparently is not responsible for the syndrome.

The second allegation, that MPD is induced by media portrayals, ignores extensive research on the effects of the media on behavior. More than 30 years of research on the relation of television viewing to violence informs us of just how difficult it is to find clear-cut effects produced by exposure to specific media imagery. Certainly there are media effects, but these effects are not simple and direct identifications. Rather they are indirect, cumulative, and heavily confounded by individual and situational variables (Friedlander, 1993). The depiction of violence in the media is vastly more common (perhaps it is even the norm for movies and television) than the portrayal of MPD. Yet, the critics of MPD would have us believe that the minuscule percentage of media time devoted to MPD is directly responsible for the increase in diagnosed cases. This would be an extraordinarily specific and powerful effect—far, far beyond anything found by the thousands of studies on violence conducted by media researchers.

The first and second accusations beg an important question. Why this disorder? If these individuals are so suggestible, why don’t they develop other disorders? Why should suggestion effects be unique to MPD? Psychiatrists inquire about and exhibit interest in other symptoms. We do not believe that asking about hallucinations produces them in a patient. Why should asking about the existence of “other parts” of the self produce alter personalities? What is so magical about this question? With respect to media portrayals of mental illness, a random channel-walk through the soap opera and talk show circuits will convince one that many other symptoms and disorders fill the airwaves. Eating disorders, obsessive-compulsive disorder, bipolar illness, assorted phobias, sexual dysfunctions, autism, chronic fatigue syndrome, etc., etc., are discussed in graphic detail and glamorized after their own fashion. Why don’t suggestible individuals identify with these conditions? Truly, if there is such a high degree of suggestive specificity to MPD, it is worthy of intensive investigation.

The third accusation, that cases of MPD are increasing “exponentially” or “logarithmically,” shows little understanding of basic mathematics. Critics often cite inflated numbers of cases without any support for their figures. I have plotted the numbers of published cases year by year, and while it is true that they have increased significantly compared to prior decades, the rise in the slope is not nearly as dramatic as the critics’ hyperbole suggests. Over the same period, other disorders, e.g., Lyme disease, obsessive-compulsive disorder, and chronic fatigue syndrome, have shown equal or faster rises in the numbers of published cases. This reflects a basic process in medicine associated with the compilation and dissemination of syndromal profiles. When symptoms that were once viewed as unrelated are organized into a coherent syndromal presentation and that information is widely disseminated, physicians begin to identify the condition more frequently. The rapid rise in the number of cases of “battered child syndrome” following the classic paper by Kempe and his colleagues is a very relevant example of this process in action. A related criticism is that a few clinicians are responsible for most of the diagnosed MPD cases. Again, a review of the MPD literature demonstrates a healthy diversity of authorship comparable with that found for other conditions.
The crucial question raised by this debate is: How should the validity of a psychiatric diagnosis be judged? Considerable thought has gone into this question. (For a more complete discussion, see The Validity of Psychiatric Diagnosis by Robins and Barrett, 1989.) Many psychiatrists endorse the model of diagnostic validity put forth by Robins and Guze in 1970 and subsequently amplified by others (Robins and Barrett, 1989). This model requires that psychiatric diagnoses satisfy aspects of three basic forms of validity: content validity, criterion-related validity, and construct validity. Content validity is probably the most fundamental form of validity for psychiatric diagnosis. It requires that the diagnostician be able to give a specific and detailed clinical description of the disorder. Criterion-related validity requires that laboratory tests, e.g., chemical, physiological, radiological, or reliable psychological tests, are consistent with the defined clinical picture. Construct validity requires that the disorder be delimited from other disorders (discriminant validity).

The clinical phenomenology of MPD has been delineated and repeatedly replicated in a series of studies of more than 1,000 cases. A review of the best of these studies demonstrates striking similarities in the symptoms of MPD patients across different sites and investigational methodologies (Coons et al., 1988; Putnam et al., 1986; Ross et al., 1990). They should convince the interested reader that a specific, unique, and reproducible clinical syndrome is being described. A small but growing body of literature on childhood and adolescent MPD links the adult syndrome with childhood precursors, establishing a developmental continuity of symptoms and pathology (Dell and Eisenhower, 1990; Hornstein and Putnam, 1992). The well-delineated, well-replicated set of dissociative symptoms that constitute the core clinical syndrome of MPD satisfies the requirements for content validity.

MPD and its core pathological process, dissociation, can be detected and measured by reliable and valid structured interviews and scales (Carlson et al., 1993; Steinberg et al., 1991). Published data on validity compare very favorably with accepted psychological instruments and satisfy the reliability requirement imposed by Robins and Guze for the inclusion of psychological tests as measures of criterion validity. These instruments have been translated into other languages and proven to discriminate MPD in other cultures. Discriminant validity studies have been conducted for the Dissociative Experiences Scale and the Structured Clinical Interview for DSM-III-R-Dissociative Module, both of which show good receiver operating characteristic curves, a standard method for evaluating the validity of a diagnostic test (Carlson et al., 1993; Steinberg et al., 1991). MPD is well discriminated from other disorders by reliable and valid tests and thus has good criterion-related and construct validates.

Multiple personality disorder has been with us from the beginnings of psychiatry (Ellenberger, 1970). At present we conceptualize this condition as a complex form of posttraumatic dissociative disorder, highly associated with a history of severe trauma usually beginning at an early age. I believe that research demonstrates that the diagnosis of MPD meets the standards of content validity, criterion-related validity, and construct validity considered necessary for the validity of a psychiatric diagnosis. The simplistic argument that MPD is individually and socially caused "hysteria" evades the much more important
question of what is the best approach to helping these patients. Denying its existence or blaming psychiatrists and television for MPD patients’ symptoms is not constructive. It is important to move beyond debate about the existence of the condition to more serious discussions of therapeutic issues.

References


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Resolved: Multiple Personality Disorder Is an Individually and Socially Created Artifact

Where's hysteria now that we need it? With DSM-IV [Diagnostic and Statistical Manual of Mental Disorders, 4th ed.], psychiatrists have developed a common language and a common approach to diagnosis. But in the process of operationalizing diagnoses, we may have lost some concepts about patient behavior. The term "hysteria" disappeared when DSM-III was published; without it, psychiatrists have been deprived of a scientific concept essential to the development of new ideas: the null hypothesis. This loss hits home with the epidemic of multiple personality disorder (MPD).

The work of Talcott Parsons (1964), David Mechanic (1978), and Isidore Pilowsky (1969) taught psychiatrists to appreciate that phenomena such as hysterical paralyses, blindness, and pseudoseizures were actually behaviors with a goal: achieving the "sick role." Inspired by Parsons, Mechanic and Pilowsky used the term "abnormal illness behavior" in lieu of hysteria. Their approach eliminated the stigma of malingering that had been implied in hysteria and indicated that patients could take on such behavior without fraudulent intent. They were describing an old reality of medical experience.

Some people—experiencing emotional distress in the face of a variety of life circumstances and conflicts—complain to doctors about physical or psychological symptoms that they claim are signs of illness. Sometimes they display gross impairments of movement or consciousness; sometimes the features are subtle and changing. These complaints prompt doctors to launch investigations in laboratories, to conduct elaborate and sometimes dangerous studies of the brain or body, and to consult with experts, who examine the patient for esoteric disease. As the investigation proceeds, the patient may become still more persuaded that an illness is at work and begin to model the signs of disorder on the subtle suggestions of the physician’s inquiry. For example, a patient with complaints of occasional lapses in alertness might—in the course of investigations that include visits to the epilepsy clinic and to the EEG laboratory

for sleep studies, photic stimulation, and nasopharyngeal leads—gradually develop the frenzied thrashing movements of the limbs that require the protective attention of several nurses and hospital aides.

Eventually, with the patient no better and the investigations proving fruitless, a psychiatric consultant alert to the concept of hysteria and its contemporary link to the “sick role” might recognize that the patient’s disorder is not an epileptic but a behavioral one. The patient is displaying movements that attract medical attention and provide the privileges of patienthood.

Talcott Parsons, the Harvard sociologist, pointed out in the 1950s that medicine was an organized component of our society intended to aid, through professional knowledge, the sick and the impaired. To accomplish this, certain individuals—physicians—are licensed by society to decide not only how to manage the sick, but to choose and distinguish the sick from other impaired people. Such an identification can provide these “sick” individuals with certain social privileges, i.e., rest, freedom from employment, and support from others during the reign of the condition. The person given the appellation “sick” by the social spokesman—the physician—was assumed by the society to respond to these privileges with other actions, i.e., cooperating with the intrusions of investigators of the illness and making every effort at rehabilitation so as to return to health. The hidden assumption is that the burdens and pains of illness act to drive the patient toward these cooperative actions with the physicians and thus to be happy to relinquish the few small pleasures that can be found in being treated as a victim of sickness.

However, because there are advantages to the sick role, there are some situations in which a person might seek this role without a “ticket of admission,” a disease. This is hardly a remarkable idea as almost anyone has noticed the temptation to “call in sick” when troubles are afoot. But in some patients—those with emotional conflicts, weakened self-criticism, and high suggestibility—this temptation can be transformed, usually with some prompting, into the conviction that they are infirm. This kind of patient may, in fact, use more and more information from the medical profession’s activities to amplify the expression of the infirmity.

Psychiatrists have known about these matters of social and psychological dynamics for more than 100 years. They were brought vividly to attention by the distinguished pupil of Jean-Martin Charcot, Joseph Babinski (he of the plantar response). Like Sigmund Freud and Pierre Janet, Babinski had observed Charcot manage patients with, what Charcot called, “hyster epilepsy.” But Babinski was convinced that hyster epilepsy was not a new disorder. He believed that the women at Charcot’s clinic were being persuaded—and not so subtly—to take on the features of epilepsy by the interest Charcot and his assistants expressed (Babinski and Froment, 1918). Babinski also believed that these women were vulnerable to this persuasion because of distressing states of mind provoked in their life circumstances and their roles as intriguing patients and the subject of attention from many distinguished physicians who offered them a haven of care.

Babinski was bringing the null hypothesis to Charcot and with it, not a rejection of these women as legitimate victims of some problem, but an appre-
ciation that behaving as if epileptic obscured reality and made helping their actual problem difficult. Babinski wrote that just as hysteroepilepsy rested on persuasion, so a form of counterpersuasion could correct it. He demonstrated that these patients improved when they were taken from the wards and clinics where other afflicted women—epileptic and pseudoepileptic—were housed and when the attention of the staff was turned away from their seizures and onto their lives. These measures—separation and counterevidence—had the advantage of limiting the rewards for the behavior and of prompting a search for and treatment of the troubles in the personal life.

All this became embedded in the concept of hysteria and needs to be reapplied in the understanding of MPD. The patients I have seen have been referred to the Johns Hopkins Health System because elsewhere they have become stuck in the process of therapy. The histories are similar. They were mostly women who in the course of some distress sought psychiatric assistance. In the course of this assistance—and often early in the process—a therapist offered them a fairly crude suggestion that they might harbor some “alter” personalities. As an example of the crudity of the suggestions to the patient, I offer this published direction of how to both make the diagnosis and elicit “alters”:

The sine qua non of MPD is a second personality who at some time comes out and takes executive control of the patient’s behavior. It may happen that an alter personality will reveal itself to you during this [assessment] process, but more likely it will not. So you may have to elicit an alter personality. . . . To begin the process of eliciting an alter, you can begin by indirect questioning such as, “Have you ever felt like another part of you does things that you can’t control?” If she gives positive or ambiguous responses, ask for specific examples. You are trying to develop a picture of what the alter personality is like. . . . At this point, you might ask the host personality, “Does this set of feelings have a name?” Occasionally you will get a name. Often the host personality will not know. You can then focus on a particular event or set of behaviors and follow up on those. For instance, you can ask, “Can I talk to the part of you who is taking those long drives to the country?” (Buie, 1992, p. 3).

Once the patient permits the therapist to “talk to the part . . . who is taking those long drives,” the patient is committed to having MPD and is forced to act in ways consistent with this role. The patient is then placed into care on units or in services—often titled “the dissociative service”—at the institution. She meets other patients with the same compliant responses to therapists’ suggestions. She and the staff begin a continuous search for other “alters.” With the discovery of the first “alter,” the barrier of self-criticism and self-observation is breached. No obstacles to invention remain.

Countless numbers of personalities emerge over time. What began as two or three may develop to 99 or 100. The distressing symptoms continue as long as therapeutic attention is focused on finding more alters and sustaining the view that the problems relate to an “intriguing capacity” to dissociate or fractionate the self.

At Johns Hopkins, we see patients in whom MPD has been diagnosed because symptoms of depression have continued despite therapy elsewhere. Our
referrals have been few and our experience, therefore, is only now building, probably because our views—that MPD may be a therapist-induced artifact—have only recently become generally known in our community (McHugh, 1995). We seem to challenge the widely accepted view and to “turn back the clock.” The referrals that come to us often arrive with obstacles to our therapeutic plans. Patients and their referring therapists often wish to stay in regular contact (two to three times weekly) and to continue their work on MPD. At the same time, we at Hopkins are expected to treat the depression or some other supposed “side issue.” We, however, following the isolation and countersuggestion approach, try to bring about, at least temporarily, a separation of the patient from the staff and the support groups that sustain the focus on “alters.” We refuse to talk to “alters” but rather encourage our patients to review their present difficulties, thus applying the concept of “abnormal illness behavior” to their condition.

The advocates for MPD are in the same position as Charcot was when Babinski offered his proposal of the null hypothesis. As in any scientific discussion, it is not the responsibility of the proposers of the null hypothesis to prove its likelihood. That hypothesis simply claims that nothing special has been discovered. I claim the same in this debate. The investigators proposing a new entity must demonstrate that the null hypothesis should be rejected.

In most of the discussions by champions of MPD just the opposite occurs. Not only is the null hypothesis discarded without any compelling reason, but nonrelevant information is presented to justify a uniqueness to MPD. Perhaps the most common proposal is that MPD must exist in the way proposed because it is included in DSM-IV and operational criteria are available to make the diagnosis. This is a misunderstanding of DSM-IV. It provides a way in which a diagnosis can be reliably applied to a patient, but it does not in any way validate the existence of the condition or negate a null hypothesis about it.

Charcot had quite reliable ways of diagnosing hysteroepilepsy. It just did not exist as he thought it did, but rather it was a behavior seeking the sick role. It is my opinion that MPD is another behavioral disorder—a socially created artifact—in distressed people who are looking for help. The diagnosis and subsequent procedures for exploring MPD give them a coherent posture toward themselves and others as a particular kind of patient: “sick” certainly, “victim” possibly. This posture, if sustained, will obscure the real problems in their lives and render psychotherapy long, costly, and pointless. If the customary treatments of hysteria are provided, then we can expect that the multiple personality behaviors will be abandoned and proper rehabilitative attention can be given to the patient.

Hysteria as a concept has been neglected in DSM-III and DSM-IV, but it offers just what it has always offered: a challenge to proposals of new entities in psychiatry. Some diagnoses survive and others do not. MPD has run away with itself, and its proponents must now deal with this challenge. Charcot took such a challenge from his student. Everyone learned in the process.
References

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