

The Sociocognitive Model of Dissociative Identity Disorder: A Reexamination of the Evidence

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According to the sociocognitive model of dissociative identity disorder (DID; formerly, multiple personality disorder), DID is not a valid psychiatric disorder of posttraumatic origin; rather, it is a creation of psychotherapy and the media. Support for the model was recently presented by N. P. Spanos (1994). In this article, the author reexamines the evidence for the model and concludes that it is based on numerous false assumptions about the psychopathology, assessment, and treatment of DID. Most recent research on the dissociative disorders does not support (and in fact disconfirms) the sociocognitive model, and many inferences drawn from previous research appear unwarranted. No reason exists to doubt the connection between DID and childhood trauma. Treatment recommendations that follow from the sociocognitive model may be harmful because they involve ignoring the posttraumatic symptomatology of persons with DID.

Within the dissociative disorders field and much of mainstream psychiatry and psychology, dissociative identity disorder (DID; formerly, multiple personality disorder [MPD])¹ is conceptualized as being a posttraumatic condition resulting from overwhelming childhood experiences, usually severe child abuse. According to this model, the dissociative response to earlier trauma is a creative survival strategy that helped the individual cope with the overwhelming trauma. Alter personalities (*alters*) are conceptualized as dissociated aspects of an individual's whole personality. Treatment based on this conceptualization focuses largely on resolving the emotional, behavioral, and cognitive effects of the trauma; reducing conflict among dissociated ego states; and ultimately achieving an integration of the total personality.

For years, there has been a vocal group of researchers and clinicians who have suggested that the posttraumatic conceptualization of DID is incorrect and that the disorder may instead represent an iatrogenic artifact of psychotherapy (Aldridge-Morris, 1989; Chodoff, 1987; McHugh, 1993; Meresky, 1992; Simpson, 1988; Spanos, 1994; Spanos, Weekes, & Bertrand, 1985). According to this sociocognitive model (Spanos, 1994), psychotherapists play the most critical role in the development of the condition by suggesting and legitimizing the concept of multiplicity, creating the symptomatology through hypnosis, and then shaping the patient's behavior through differential reinforcement. The media have also hypothetically led to the increased creation of the disorder by the presentation of cases such as *Eve* (Thigpen & Cleckley, 1957) and *Sybil* (Schreiber, 1973), which have legitimized the con-

dition and helped the general public learn how to enact the role of an individual with DID.

Treatment based on the sociocognitive model differs radically from that described above. The therapist does not discuss and legitimize the concept of multiplicity. Alters, if they appear to be present, are ignored to avoid reinforcement of the pathological behavior (McHugh, 1993). Presentation of symptoms of DID is interpreted as based on a need for attention. Treatment focuses almost exclusively on here and now problems (Fahy, Abas, & Brown, 1989; McHugh, 1993). On the basis of the assumption that DID is unrelated to childhood trauma and that many of the reports are false, patient's reports of abuse, especially if reported by alters, are interpreted as fantasy, based on a further need for attention, or caused by previous inappropriate therapy (Spanos, 1994).

Numerous critiques of the iatrogenic position have been published in the literature (Boon & Draijer, 1993b; Kluft, 1989; Ross, 1989, 1990; Ross, Norton, & Fraser, 1989; Spiegel & Cardena, 1991). The conclusions reached by these researchers have generally been that, although some of the phenomena of DID can be created iatrogenically, there is no evidence to suggest that the disorder *per se* can be created. Thus, the iatrogenesis mechanism is insufficient to explain all or even many reported cases of the disorder. Carson and Butcher (1992) and Ross (1990) have also noted that the all-or-nothing assumption of the iatrogenic model is false because no disorder can be entirely iatrogenic or entirely noniatrogenic.

Despite these criticisms, Spanos (1994) presented an addi-

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¹ Because of the name change in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994), the term *dissociative identity disorder* is used throughout this article, except where direct quotes referred to the prior name, *multiple personality disorder*. The criteria for the disorder are essentially unchanged with the exception of the addition of an amnesia criterion in the *DSM-IV*. All cited prevalence studies of DID included an amnesia criterion in making clinical diagnoses.

tional, somewhat extensive review of the literature on *multiple identity enactment*, which he argued supported the sociocognitive model of DID. He suggests that the evidence was conclusive enough to recommend that the posttraumatic model be abandoned in favor of his alternative model. The purpose of this article is to more closely examine the evidence presented by Spanos and other recent proponents of the sociocognitive model of DID, as well as relevant clinical and empirical literature on the dissociative disorders, to thoroughly examine if the data support the sociocognitive model.

Assumptions of the Sociocognitive Model

The sociocognitive model, as defined by Spanos (1994), appears to be based on numerous assumptions about DID regarding its core psychopathology, clinical presentation, assessment, treatment, and prevalence. The first assumption is that multiple identity enactment is the core psychopathology of DID. Spanos's initial premise was that "people who receive the diagnosis of multiple personality disorder (MPD) behave as if they have two or more distinct identities" (Spanos, 1994, p. 143). He then presented a wealth of data on various forms of multiple identity enactment (possession, past-life regression, transvestism, and speaking in tongues), which he argued supported his model of DID.

The second assumption is that individuals who are diagnosed as having DID are generally attention seeking (histrionic) and obvious in their clinical presentation. The model relies on this assumption in two ways. First, it is used to explain why an individual might want to fake having DID. For example, Spanos (1994) suggests that gaining attention was the main motivating factor for enacting the role of the patient with DID. Second, the assumption is used to argue that, because of its floridly obvious symptoms, DID should be easily recognized. Spanos stated that

a patient who calls herself Mary on one day and Jane on another and who behaves very differently as Mary than as Jane is unlikely to go unrecognized as a candidate for an MPD diagnosis by even an inexperienced clinician. (Spanos, 1994, pp. 152-153)

A related assumption is that there is something unique about DID that would make it rewarding for an individual to simulate the disorder. The assumption is that persons diagnosed with DID generally receive special, preferential treatment. The type of special treatment refers back to attention. Thigpen and Cleckley (1984) stated that "certainly a diagnosis of multiple personality attracts a good deal more attention than most other diagnoses" (p. 64), and North, Ryall, Ricci, and Wetzel (1993) stated that DID is a highly effective means of gaining attention.

The fourth and fifth assumptions of the sociocognitive model relate to the assessment and treatment of DID. According to the model, the methods of assessment and treatment of DID actually create or worsen the condition. The two assumptions are (a) that DID *can* be created iatrogenically and (b) that the most common assessment and treatment procedures use the methods that can create DID.

The sixth assumption of the sociocognitive model is that the data suggest that iatrogenic processes have been at work in either creating DID or altering its phenomenology. Data cited to

support this are generally the recent increases in the frequency with which the disorder has been reported, alleged differences in prevalence rates from numerous prevalence studies and cultures, and alleged changes in the symptomatology of DID over time.

Multiple Identity Enactment and DID

The sociocognitive model appears to begin with the assumption that multiple identity enactment and DID are equivalent phenomenon. For example, in Spanos's (1994) article, he presented three sources of data that he claims demonstrated the flaw in the posttraumatic model of DID. He wrote

(a) *multiple identities* are usefully conceptualized as rule-governed social constructions, (b) neither childhood trauma nor a history of severe psychopathology is necessary for the development or maintenance of *multiple identities*, and (c) *multiple identities* are established, legitimized, maintained, and altered through social interaction. (p. 143) [italics added]

To support these statements, Spanos presented a wealth of data suggesting that multiple identity enactment may be a relatively common phenomenon which has appeared in numerous forms throughout history (e.g., transvestism, possession, and mediumship). However, as can be seen, each of these arguments (regardless of its validity or lack thereof) pertains to the general behavior of multiple identity enactment.

In reality, available data do not support the assumption that multiple identity enactment and DID are equivalent phenomenon or that the former is the core psychopathology of the latter. Rather, recent research suggests that a group of dissociative symptoms appears to be the core psychopathology of DID. Researchers of several independent studies (Boon & Draijer, 1993b; Coons, Bowman, & Milstein, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross et al., 1990; Ross, Norton, & Wozney, 1989; Schultz, Braun, & Kluff, 1989), based on 50 to over 350 cases, have collectively documented a relatively clear set of clinical DID features, which include dissociative symptoms such as amnesia (including ongoing amnesia and lack of autobiographical memory for childhood), chronic depersonalization and derealization, Schneiderian symptoms (hearing voices and passive influence experiences), and identity alteration (which is not synonymous with multiple identity enactment).²

These dissociative symptoms, measured by objective means, have been found to discriminate patients with DID from those with a variety of other disorders including schizophrenia (Fink & Golinkoff, 1990; Ross, Heber, Norton, & Anderson, 1989; Steinberg, Cicchetti, Buchanan, Rakfeldt, & Rounsaville,

² *Identity alteration* is a more general term for the objective behaviors that are manifestations of the assumption of different identities (Steinberg, 1993). It includes not only behaving like a different person but also disremembered behaviors, finding possessions for which one cannot account, hearing voices and carrying on internal or written dialogues between dissociated ego states, spontaneous age regressions to traumatic events, and referring to oneself as "we." Overtly behaving as if one were a different person does not appear to be typical of the clinical presentation of DID (see Clinical Presentation below).

1994), eating disorders (EDs; Gleaves, Eberenz, Warner, & Fine, 1995; Ross, Heber, Norton, & Anderson, 1989), panic disorder (Ross, Heber, Norton, & Anderson, 1989), borderline personality disorder (Boon & Draijer, 1993b; Fink & Golinkoff, 1990), partial complex seizures (Ross, Heber, Anderson, et al., 1989), simple posttraumatic stress disorder (Dunn, Ryan, Paolo, & Miller, 1993), and dissociative disorder not otherwise specified (DDNOS; Ross, Anderson, et al., 1992).

Given that recent research has demonstrated the complex psychopathology of DID, equating the disorder with one specific but broadly defined behavior (multiple identity enactment) is clearly unwarranted. The latter should be conceptualized as one observable behavior that may or may not be related to a feature of the disorder (identity alteration). As an analogy, equating major depressive disorder with "acting sad" would be similarly unwarranted because the former is a complex depressive disorder characterized by a clear group of depressive symptoms, whereas the latter is one specific behavior that may or may not be related to one of the symptoms of the disorder (sad affect). One could also easily generate a list of factors that affect whether one acts sad that would have little relevance to the complex psychopathology of depressive disorders.

In summary, multiple identity enactment and DID are not equivalent phenomenon, and the former does not appear to be the core psychopathology of the latter. Conclusions based solely on data relevant to the concept of multiple identity enactment cannot be generalized to the complex dissociative psychopathology of DID.

Clinical Presentation, Attention Seeking, and DID

The assumption that individuals diagnosed as having DID are histrionic (attention seeking) and obvious in their presentation of identity-related symptoms is common among skeptics of the disorder. To support this description, Spanos (1994) referred to the opinion of Thigpen and Cleckley (1984), who stated that many patients contacting them after publication of their book, *The Three Faces of Eve* (1957), appeared to be motivated (consciously or unconsciously) by a desire to draw attention to themselves.

Although numerous individuals have drawn conclusions about DID from Thigpen and Cleckley's (1984) remarks, doing so is unwarranted because they were referring to individuals who (in Thigpen and Cleckley's opinion) did *not* have DID. How they could ascertain unconscious motivation mainly from phone conversations is also unclear. Furthermore, the description of the clinical presentation of DID offered by Spanos (1994), that of someone who openly calls herself or himself by different names and behaves like different people on different occasions, is quite different from that described within the dissociative disorders literature. Clinicians and researchers within the field have regularly reported that patients with DID more commonly make active efforts to conceal the disorder because of fear of being labeled *crazy*, fear of disclosing their abuse histories, distrust of others, or a general *avoidant* characterological style (Cohen, Giller, & W., 1991; Kluff, 1991a, 1994).

Ultimately, the question of clinical presentation and characterological style of patients with DID should be an empirical

one, and the accumulating data do not support the position that individuals with DID or other severe dissociative psychopathology are generally histrionic or otherwise characterologically attention seeking in nature.

Table 1 presents data from two recent studies of Axis II (personality disorder) diagnoses among patients having DID as compared with studies of other general clinical or nonclinical samples; diagnoses were made by structured interviews in all studies. As can be seen, the prevalence of histrionic personality disorder appears to be no higher and, in actuality, lower than in other general or specific clinical and nonclinical samples. However, avoidant personality disorder was found to be common in both of the DID samples³ and was more common than in any of the clinical or nonclinical samples.

Additional data also question the association between DID and histrionic symptomatology. Armstrong and Loewenstein (1990) administered a variety of objective and projective testing instruments to group of 14 patients with DID. The authors concluded that the personality profiles of the patients with DID were not histrionic or labile but rather were intellectualized, obsessive, and introversive.

Fink and Golinkoff (1990) administered the Millon Clinical Multiaxial Inventory-II (MCMI; Millon, 1982) to a sample of 16 patients with DID, as well as to a sample of patients with borderline personality disorder or schizophrenia. Although the percentage of patients meeting established cutoffs was not reported, the mean base rate score for the Histrionic scale of the MCMI was only 46.3 for the DID group, well below the cutoffs for the presence of prominent traits. The patients scored highest on the Avoidant scale (102.9), followed by the Self-Defeating scale (97.3).

Other researchers have compared patients that scored high or low on standardized dissociation scales. Goff, Olin, Jenike, Baer, and Buttolph (1992) administered the Dissociative Experiences Scale (DES), along with several assessment instruments including the Structured Interview for *DSM-III* Personality Disorders-Revised (SIDP-R; Stangl, Pfohl, Zimmerman, Bowers, & Corenthal, 1985), to a sample of 100 clinical patients and then examined personality disorder diagnoses in the 20 highest and 20 lowest scorers on the DES. Among the 20 high scorers, only 1 (5%) received a diagnosis of histrionic personality disorder. Fourteen of the 20 were diagnosed as having avoid-

³ The diagnosis of borderline personality disorder was also found to be common in these two studies. To thoroughly discuss the connection between borderline personality disorder and DID would be beyond the scope of this article. In general, research demonstrates that, although there is some overlap in phenomenology, the core symptomatology of the two disorders may not be highly related (Gleaves & Eberenz, 1995b), and a cluster of dissociative and Schneiderian symptoms discriminates the two disorders (Boon & Draijer, 1993b; Fink & Golinkoff, 1990). The overlap in some symptomatology is not surprising given the association of borderline personality disorder (BPD) with both childhood trauma (Herman, Perry, & Kolk, 1989; Murray, 1993) and posttraumatic stress disorder (PTSD; Gunderson & Chu, 1993; Gunderson & Sabo, 1993; Southwick, Yehuda, & Giller, 1993). This latter association also questions the commonly made interpretation of borderline patients' self-injurious behaviors as purely attention seeking (Briere, 1992; Gunderson & Chu, 1993).

Table 1
Prevalence of Histrionic Versus Avoidant Personality Disorder Among Patients With DID and General Clinical and Nonclinical Samples

Study	N	% histrionic	% avoidant
DID			
Ellason et al. (in press)	103	9	49
Lauer et al. (1993)	14	14	50
Clinical ^a			
Dahl (1986)	103	19	9
Frances et al. (1984)	76	22	21
Loranger et al. (1987)	60	15	7
Pfohl et al. (1986)	131	19	11
Widiger et al. (1987)	84	45	33
Zanarini et al. (1987)	43	42	35
Nonclinical			
Reich et al. (1989)	235	2	0
Zimmerman & Coryell (1989)	797	3	1
Nestadt et al. (1990)	810	2	—
Maier et al. (1992)	452	1	1

Note. DID = dissociative identity disorder. The dash indicates that the characteristic was not assessed.

^a Frances et al. (1984) assessed outpatients; all the other studies evaluated inpatients.

ant ($n = 5$), obsessive-compulsive ($n = 5$), or dependent ($n = 5$) personality disorders.

A similar analysis was conducted by Ross, Ryan, Voigt, and Eide (1991) in a nonclinical sample. Ross et al. administered the DES to a sample of 345 college students and then compared the highest scorers (above 22.6) with the lowest scorers (below 5.0) on the MCMI. The two groups did not differ on the Histrionic scale of the MCMI, and the largest differences were found on the Avoidant scale.

One additional study examined the relationship between dissociative symptoms (the core symptomatology of DID) and personality disorder variables. Gleaves and Eberenz (1995b) recently administered two dissociation scales (the DES and the Trauma Symptom Checklist), along with the MMPI-2, to a sample of 53 clinical patients and examined the relationship between the dissociation scales and the Morey personality disorder scales (Morey, Blashfield, Webb, & Jewell, 1988). Dissociative symptoms were found to be slightly negatively correlated with histrionic symptomatology and were most highly positively correlated with schizotypal and avoidant symptomatology.

Although additional studies such as those by Ellason, Ross, and Fuchs (in press) and Lauer, Black, and Keen (1993) would be helpful, available data do not support the hypothesis that patients with DID are histrionic to a greater degree than patients with any other Axis I mental disorder or that the core symptomatology of patients with DID is associated with a tendency to draw attention to oneself. The data suggest that dissociative symptoms and disorders may be more often associated with an avoidant characterological style.

Motivations for Having DID

Proponents of the sociocognitive model of DID have stated that patients diagnosed as having the disorder receive preferential or special treatment and that DID represents a highly effective means of gaining attention (North et al., 1993; Spanos, 1994). Given the data described above, it seems unlikely that individuals who are, more often, avoidant would be strongly motivated by the need for attention. Furthermore, the apparently common perception that patients diagnosed as having DID receive preferential treatment is inconsistent with the way patients having DID are most commonly treated in the mental health system (Cohen et al., 1991; Dell, 1988; Greaves, 1989).

In most mental health settings, patients diagnosed as having DID or who present symptoms of DID appear to experience especially hostile treatment. When these patients are hospitalized with a diagnosis of DID, staff (sometimes including unit directors) often tell them that they are lying or faking, their diagnosis is incorrect, or even that their therapists are crazy (Cohen et al., 1991; Greaves, 1989; Kluft, 1985). Patients with DID are often told that they are actually psychotic or borderline, and in many hospital settings the terms *multiple* and *borderline* are used as if they are synonymous (Cohen et al., 1991). Both Greaves and Dell (1988) have provided numerous examples of the type of extreme and nonprofessional skepticism that patients and therapists receive regarding the diagnosis.

Another subgroup of therapists seem to believe that the disorder is genuine but appear to become so fascinated with the phenomenology of DID that they may ignore their patients' suffering and focus instead on the phenomenology of the disorder. Such therapists sometimes put their patients "on display" for professional colleagues who are called in as "consultants," and they may also ask the patients if they are willing to be presented by the therapist at live or videotaped case conferences. Although such behaviors could clearly be described as attention, it is a type of attention that may actually be somewhat aversive to a group of individuals who are more often avoidant and have excessive social anxiety. For some patients who have histories of more formal exploitation (e.g., child pornography and prostitution), such treatment may feel quite reminiscent of their traumatic childhoods.

The assumption that patients with DID find having DID enjoyable or rewarding is also inconsistent with what these individuals have actually said about their experiences. Numerous first-hand descriptions of what it is like to suffer from and be treated for DID were included in a book entitled *Multiple Personality Disorder From the Inside Out* (Cohen et al., 1991). In describing what it is like to have DID, one individual stated, "It feels ugly, dirty, and repulsive. It feels like being the elephant man . . . Dying would be better." (p. 25). Another stated, "The experience of MPD is hell . . . We wouldn't wish this on anyone." (p. 24). Concerning her understanding of what DID was, one patient stated, "We believed MPD was crazy—that it was some kind of defective disease. Having the diagnosis applied to us was proof that we were evil and didn't deserve to be alive" (p. 1). Others described the phenomenon of "vanishing friends" (p. 89) that often follows the diagnosis of DID due to friends' perception that the disorder is something "freakish."

In speaking about previous treatment experiences one patient noted:

Not only have I experienced skepticism from other therapists, but also downright rudeness! . . . Many of the doctors which I and the "others" have encountered told me that my diagnosis was incorrect, my doctor did not know what he was talking about, I was lying, looking for attention or just wanting to be fashionable. This type of skepticism and disharmony within the psychiatric community almost made me want to hide the evidence of the disorder. That's falling back into the same pattern of secretiveness which I was trying to overcome (Cohen et al., 1991, pp. 85-86).

In summary, the conclusion that having DID is generally rewarding is unfounded because the vast majority of the attention such patients receive is skeptical, critical, exploitative, or hostile; they are often ignored if they do present symptoms of DID. It is certainly possible that some individuals have attempted to feign the disorder. However, the hostile treatment that one would most likely receive would make feigning another disorder more rewarding.

Creating Multiplicity

Assessment of Dissociative Disorders

Proponents of the sociocognitive model of DID suggest that the assessment procedures used by clinicians who treat dissociative disorders create the disorder by suggesting and legitimizing the symptomatology (Spanos, 1994). Thus, the argument is that the patient does not walk into the assessment experiencing the symptoms in question but reports them over time following the suggestions, cuing, and leading of the therapist.

According to proponents of the model, DID is allegedly created by the specifics of the assessment process, most notably hypnosis. Spanos (1994) stated that hypnosis was the most common procedure used to assess for multiplicity (p. 153) and that the hypnotic interviews used were "highly reminiscent of Catholic exorcism procedures" (p. 154). However, these statements, which were made without empirical support, are contradicted by available data. Out of the 214 DID cases reported by Ross, Norton, and Wozney (1989), only 58 (27%) had been hypnotized before making the diagnosis. More striking, although not stated in the report, only 2 (4%) of the 50 patients reported by Coons, Bowman, and Milstein (1988) had ever been hypnotized (P. M. Coons, personal communication, October 20, 1994).

The state-of-the-art assessment of dissociative disorders is through the use of structured interviews, such as the Structured Clinical Interview for *DSM-IV* Dissociative Disorders (SCID-D; Steinberg, Cicchetti, Buchanan, Hall, & Rounsaville, 1993). The SCID-D is consistent in format with other modules of the SCID and systematically guides the evaluator through the assessment of five domains of dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration.

Studies of the SCID-D have found it to lead to highly reliable diagnoses of DID. Steinberg, Rounsaville, and Cicchetti (1990) reported a kappa coefficient of .90 for the diagnosis of DID and .92 for the presence of a dissociative disorder. Similar estimates

have been found in recent multicenter field trials (see Steinberg et al., 1993) and in a series of studies from the Netherlands (Boon & Draijer, 1993b). The positive results from the reliability analyses conducted by Boon and Draijer were particularly interesting because they included raters with varying levels of knowledge of (and skepticism about) dissociative disorders.

Researchers have now used the SCID-D in numerous studies of the phenomenology and prevalence of dissociative disorders (see Steinberg et al., 1993, for a review). Other researchers of recent studies on the prevalence and psychopathology of dissociative disorders have used the Dissociative Disorders Interview Schedule (DDIS; Ross, Heber, Norton, Anderson, et al. 1989), another structured interview that has also been shown to yield reliable and valid results (Ross, 1989).

Another recent advancement in the objective assessment of dissociative disorders has been the development of psychometrically sound self-report measures. The instrument that has received the most use has been the DES (Bernstein & Putnam, 1986). Carlson and Putnam (1993) presented a review of research that had been conducted on the DES. In general, it has been found to have good reliability and validity. Test-retest reliability has been found to range from approximately .80 to .96 (Bernstein & Putnam, 1986; Frischolz et al., 1990), and internal consistency has repeatedly been found to exceed .90 (Frischolz et al., 1990; Gleaves et al., 1995). The DES has been found to demonstrate good convergent and discriminant validity when administered along with instruments measuring similar and different constructs (Gleaves & Eberenz, 1995a).

Numerous studies have also found the DES to be able to accurately discriminate patients with DID from other clinical and nonclinical samples. Boon and Draijer (1993b) administered the DES to a sample of 43 patients with a dissociative disorder (DID, $n = 20$; DDNOS, $n = 23$) and to 36 psychiatric controls. Using a simple cutoff score, the researchers found the DES to have a sensitivity of .93 and a specificity of .86 in accurately classifying patients as having DID.

Carlson et al. (1993) conducted a similar study using a sample of over 1,000 psychiatric patients diagnosed as having DID ($n = 228$), a dissociative disorder other than DID ($n = 117$), or one of six other nondissociative psychiatric disorders. Using a simple cutoff score, the researchers found the DES to have a sensitivity of .74 and a specificity of .80 in the accurate classification of patients with DID. Most of the patients with false positive diagnoses of DID had either PTSD or a dissociative disorder other than DID.

Gleaves et al. (1995) administered the DES, along with the Questionnaire of Experiences of Dissociation (QED; Riley, 1988), to 200 participants who were diagnosed as having DID ($n = 15$), ED ($n = 15$), or were controls ($n = 170$). Using DES factor scores in a discriminant analysis, they were able to differentiate patients with DID from those having ED with 100% accuracy and from controls with 99% accuracy. Accuracy of classification using the QED was 90% and 92%, respectively, for patients with ED and for controls. In another study of the QED, Dunn et al. (1993) used the instrument to discriminate patients with DID and controls with 100% accuracy (based solely on a cutoff score). When used to discriminate patients with DID from those with simple PTSD, the QED was found to

optimally have a sensitivity of .83 and a specificity of .87. Thus, both of these scales appear to yield reliable and valid results.

Laboratory Creation of DID-Like Phenomena

Clearly, the state-of-the-art assessment of dissociative disorders does not involve hypnosis. However, even if hypnosis is used in the assessment of DID, can one conclude that hypnosis can create the disorder? Proponents of the sociocognitive model of DID frequently cite laboratory studies demonstrating that phenomena similar to that of DID can be elicited in controls through hypnosis (Harriman, 1942a, 1942b, 1943; Kampman, 1976; Spanos, Weekes, Menary, & Bertrand, 1986). Spanos (1994) also cited studies on the hidden observer phenomenon (e.g., Spanos, Flynn, & Gwynn, 1988) and past-life regression (e.g., Spanos, Menary, Gabora, DuBreuil, & Dewhirst, 1991) as supporting the sociocognitive model.

Whereas these studies raise interesting questions about the capacities and workings of the human mind, they do not allow one to infer that DID can be iatrogenically created. For one reason, none of the studies involved the creation of DID, only phenomenon that is superficially similar (Braun, 1984; Coons, 1991; Kluft, 1989; Ross, 1989, 1990). In none of the studies did participants experience any of the established features of DID, such as episodes of time loss, depersonalization or derealization, hearing voices, having flashbacks or nightmares, or believing that their body contained more than one person.

Inferring about the naturally occurring etiology of DID from these laboratory studies is also unwarranted because the phenomenon of any mental disorder can also be induced in controls. Phenomenon of EDs (food preoccupation and binge eating) can be induced in control volunteers by extended periods of starvation (Keys, Brozek, Henschel, Michelsen, & Taylor, 1950). Depressed mood can be induced by either cognitive mood induction techniques (e.g., Velton, 1968) or pharmacological methods (e.g., reserpine; Schildkraut & Kety, 1967). Psychotic symptoms can be induced by pharmacological methods (amphetamines; e.g. Baldessarini, 1985), and symptoms of panic can be induced by numerous pharmacological or behavioral methods (Clum & Pickett, 1984). Evidence of this type has never been interpreted to suggest that anorexia or bulimia nervosa, major depression, schizophrenia, or panic disorder are not valid psychiatric disorders, and it would be illogical to do so.

Hypnosis and the Features of DID

Data also suggest that the use of hypnosis may be unrelated to DID features. In their analysis of 100 patients with DID, Putnam et al. (1986) found no differences between the clinical presentation, symptomatology, alters, or past history of patients treated with hypnosis and those treated without it. Similarly, Ross and Norton (1989) compared samples of patients with DID who had either been hypnotized both before and after diagnosis or not been hypnotized before or after diagnosis. The groups did not differ in terms of the presence of each National Institute of Mental Health (NIMH) diagnostic criterion (Hornstein & Putnam, 1992) or the number of alters.

Role-Playing Investigations and DID

Also relevant to the issue of the assessment of dissociative disorders are a series of role-playing studies (Spanos et al., 1985, 1986) that have been cited as supporting the sociocognitive model of DID. In these studies, role-playing controls exhibited some of the overt symptoms of multiplicity, including adopting a different name, referring to the primary personality in the third person, and displaying amnesia for their role-played alters. Some also described their childhoods as being traumatic. Research of this type certainly has merit, particularly in the arena of forensic psychology where those accused of crimes may attempt to role-play one of many mental disorders as a defense strategy. However, to conclude that these studies prove that DID is simply a form of role-playing is unwarranted because the role-playing of a subjective personality does not duplicate the whole complex dissociative posttraumatic phenomenology of DID (Coons, 1991). Perhaps more to the point, Carson and Butcher (1992) recently concluded that

such role playing demonstrations are interesting in various ways, but they do not answer, nor even convincingly address, the question of the reality of MPD. That college students might be able to give a convincing portrayal of a person with a broken leg would not, after all, establish the nonexistence of broken legs (p. 209).

Thus, role-playing studies do not allow one to make inferences about the etiology of any mental disorder, including DID.

Treatment of Dissociative Disorders

Supporters of the sociocognitive model of DID state that the most commonly practiced treatment of DID may actually create or worsen the disorder. To support this argument, proponents of the model make numerous characterizations about the treatment of patients with DID. They argue that the treatment, as they describe it, serves to worsen or create the condition. For example, Spanos (1994) stated that "therapists routinely encourage patients to construe themselves as having multiple selves, provide them with information about how to convincingly enact the role of 'multiple personality patient,' and provide official legitimization for the different identities that the patients enact" (p. 144). Spanos also stated that, through treatment, "MPD patients come to believe that their alter identities are real personalities rather than self-generated fantasies" (p. 147).

A review of the dissociative disorders treatment literature suggests that the characterizations offered by Spanos (1994) about the treatment of DID are, at best, lacking in support. That is, no sources were provided for the statements that he made, and they are at odds with what is recommended in the clinical treatment literature on DID (Barach, 1994; Bloch, 1991; Kluft, 1991b; Kluft & Fine, 1993; Putnam, 1989; Ross, 1989). According to this treatment literature, one of the goals of treatment for DID is to help the individual understand that the alters *are* in fact self-generated, not to convince the patient that alters are real people or personalities. Patients may enter treatment believing that parts of themselves are separate entities or people, but this is regarded as being a cognitive-percep-

tual error (Ross, 1988), and a stated goal of treatment is to communicate this to the patient (Putnam, 1989; Ross, 1989).

Conceptualizations of alters. Proponents of the sociocognitive model suggest that the issue of alters should not be legitimized by making a diagnosis of DID, speaking about alters as if they are *real* or *genuine*, or both. Rather, proponents recommend that alters should be ignored (e.g., McHugh, 1993). The argument is based on the logic that to speak of alters as real would reify them in the minds of a confused and suggestible patient, thus worsening his or her condition.

This common argument appears to be based on misunderstandings over the phenomenology of DID, the use and meaning of the terms *real* or *genuine*, and the recommended therapy of DID. Skeptics of the reality of DID seem to assume that therapists who treat patients with DID conceptualize alters as different people or entities or conceptualize patients with DID as having more than one personality. Skeptics then use such a conceptualization to express doubt about the reality of the condition. For example, in their review, North et al. (1993, p. 31) cited Prasad's statement that "the concept that more than one person may exist within one body is so alien to common sense that it borders on the supernatural." Although this perception may be quite common, it is in fact a misconception.

This common confusion over the phenomenology of DID may have been caused by the media's descriptions of the disorder or by the previous diagnostic label (multiple personality disorder), which seemed to imply the presence of more than one personality. However, several researchers (e.g., Kluft, 1988; Ross, 1990) have noted that the label was a misnomer, and the confusion of terms is what led to the recent name change in the *DSM-IV*. David Spiegel, who was chair of the *DSM-IV* work group on dissociative disorders, described that the reason for the change was to emphasize the fundamental problem of the disorder, that of "a difficulty in integrating various aspects of personality rather than a profusion of personalities" (Fraser, 1994, p. 11).

However, research does demonstrate that patients with DID report experiencing dissociated parts of themselves as separate people or entities (Ross et al., 1990). In many cases, such a quasi-delusional perception may lead to severe acts of self-injury (e.g., "It's not my body, it's hers"). What is critical to understand is that acknowledging a patient with DID to have *genuine experience* of alters as real people or entities is not the same as stating that alters are actually real people or entities.

An analogy with another mental disorder may help clarify the distinction. Many individuals with anorexia nervosa state that they experience themselves as obese, even though they are emaciated. To tell such a patient that one understands and believes that he or she experiences the self in that fashion is not the same as stating that he or she is truly obese. Such a patient would then generally be told that the experience is a symptom of anorexia and that an ultimate goal of therapy would be to not experience the self as such. Such an intervention does not validate the reality of the patient's perception, only that he or she *has* such a perception. This type of interpretation is similar to that recommended in the dissociative disorders treatment literature (Barach, 1994; Putnam, 1989; Ross, 1989). Patients' alters are legitimized as the genuine experience of the patient. However,

alters are explained and conceptualized as parts of a whole person, not as separate people or entities.⁴

Most mental health professionals would probably agree that it would be inappropriate to tell a patient with anorexia nervosa that one simply does not believe his or her perceptions, that he or she was making them up for attention, or that it was inappropriate to talk about them. Ignoring statements about such perceptions would seem similarly inappropriate, even though doing so would probably lead to their decrease. However, this is the type of response that proponents of the sociocognitive model of DID recommend in treating individuals with DID.

Even with this more accurate description of how the phenomenology of DID is communicated to the patient, proponents of the sociocognitive model might still argue that speaking to alters as if they were different people still reifies the experience, even if one states that alters are all part of one person. However, this position would also be a misinterpretation of the clinical treatment literature on DID. The general recommendation is that one speaks with alters to understand all aspects of the person in therapy but not as if they were different people. Kluft (1993) noted that consistency across alters is the most powerful assault on the patient's dissociative barriers. He also noted that the patients with DID whose therapist changes in response to each alter has "multiple therapist disorder."

The question of the effect of talking to alters is an empirical one that should be tested before firm conclusions can be drawn. As part of treatment outcome studies, data on the perception of separateness among alters should be collected. However, the clinical data available at this time suggest that, over time, the delusional perceptions and beliefs of separateness decrease and eventually disappear (Kluft, 1984; Putnam, 1989; Ross, 1989). Alters who once argued that they were separate people gradually become more similar through therapy. The effective processing of critical trauma memories is said to lead to decreases in perceived separateness,⁵ and alters are reported to frequently spontaneously "integrate" or disappear after such emotional work is done (Putnam, 1989; Ross, 1989).

Environmental treatment of DID. In support of the sociocognitive model, Spanos (1994) referred to a case reported by Kohlenberg (1973) in which behavior modification was used to reduce the frequency of a patient presenting different alters. Fahy et al. (1989) and North et al. (1993) presented similar examples. The results of such studies have been used to support the position that alters exist purely or largely as a result of social reinforcement (Spanos, 1994).

There are many problems with these reports and the conclusions drawn from them, most important, the conclusion that the reports support the sociocognitive model of the etiology of

⁴ I readily acknowledge that, within the media, alters have often been conceptualized as different persons. This has clearly contributed to the prevalence of many misconceptions about the disorder.

⁵ *Processing* is used as a general term to describe the memory work on patients with dissociative disorder. Within the dissociative disorders literature, the term *abreaction* is most often used. However, the actual techniques used are basically equivalent to exposure-based cognitive-behavioral interventions (e.g., Resick & Schnicke, 1992; Rothbaum & Foa, 1992).

DID. For one reason, to do so would be to argue that one can infer etiology from response to treatment, which cannot logically be done. The iatrogenic model was also clearly not supported by Fahy et al.'s (1989) case report because they had corroborating evidence (based on records for emergency room visits) that the patient had experienced clear DID symptoms before she was in treatment or had read any information about dissociative disorders.

Another problem with the conclusions drawn from the case reports on environmental-behavioral treatment of DID is that the posttraumatic model of DID would make the same prediction regarding how an individual would respond to such an intervention. Individuals raised in highly abusive, traumatic childhoods generally have great difficulties trusting others; telling or communicating to a patient (by ignoring him or her) that it is not appropriate to behave that way or to talk about one's experiences would not seem to be an effective means of fostering trust. In practice, the strategies described by Kohlenberg (1973), Fahy et al. (1989), and North et al. (1993) are frequently applied to patients with DID in psychiatric facilities that do not specialize in the treatment of dissociative disorders. What patients later stated about their experiences with such interventions is that they quickly learned when, where, and to whom it is safe to be "themselves" and talk about their experiences and symptoms (Cohen et al., 1991). Thus, according to what patients later stated, alters and other dissociative symptoms do not go away; rather, the patients simply stop trusting their therapist and lose hope in the therapist's ability to understand and treat their symptoms.

If the posttraumatic conceptualization of DID is correct, then one should also strongly question whether the types of intervention referred to by Spanos (1994) are helpful for the patients, even if the interventions do seem to have to have an effect on overt behavior. If the target behavior had involved another posttraumatic symptom, such as intrusive thoughts, one could easily predict that a behavioral intervention that discouraged the patient from talking about having intrusive thoughts of sexual abuse, for example, would most likely lead to a decrease in the behavior. However, this could not be taken as evidence that the person actually benefited from the intervention. In fact, it would appear to be countertherapeutic and possibly harmful.

Researchers of several large-scale studies have found that patients who are ultimately diagnosed as having DID have spent an average of approximately 7 to 8 years in the mental health system before being diagnosed as having DID, generally without having made progress (Boon & Draijer, 1993b; Putnam et al., 1986; Ross et al., 1990; Ross, Norton, & Wozney, 1989). Of these hundreds of patients with DID, not addressing and treating the dissociative condition did not lead to clinical improvement.

Furthermore, neither the report by Kohlenberg (1973) nor by North et al. (1993; where trauma was not reported to have been addressed) included evidence that the patients meaningfully benefited from the intervention. Dissociative symptoms were not objectively evaluated, and North et al. actually stated that, following the intervention, the patient developed urges to cut off her legs and that her course was chronic and consistent with borderline personality disorder or somatization disorder.

Perhaps her condition was chronic because her dissociative disorder was not actually treated.

Conversely, Fahy et al. (1989) clearly did not avoid dealing with the patient's sexual abuse history. They stated that she was encouraged to openly discuss her history of sexual abuse and that her alters became less dominant as she did so. This observation is basically identical to that made within the dissociative disorders literature; thus, it is hard to understand how those who have cited this study interpreted this effect as supporting the iatrogenic model.

Evidence of Premorbid Conditions

The argument that the assessment process or treatment causes the disorder to develop also fails to explain any evidence that the dissociative disorder existed before the patient began treatment for DID. For example, Fahy et al. (1989) documented (from emergency room visit records) that the patient in their case report had experienced DID symptoms well before she was in treatment or had encountered literature on DID. Similarly, in the sample of 50 patients with DID reported by Coons et al. (1988), amnesia (a core symptom of DID) was a *presenting* symptom in all 50 patients. Furthermore, patients diagnosed as having DID almost invariably reported having experienced their dissociative symptoms since childhood and often had evidence to support such reports (Gleaves & Warner, 1995). Patients frequently had journals dating back to childhood that have several distinct sets of handwriting, much of which the patients reported no memory for having written. Friends and family members are also often able to document the dissociative symptoms that patients with DID have exhibited throughout their lives (Gleaves & Warner, 1995).

In summary, the data do not support the hypothesis that assessment or treatment procedures are responsible for the creation of DID. State-of-the-art assessment of dissociative disorders is consistent in format with that of other mental disorders, and recent prevalence studies and large-scale investigations on the clinical features of the disorder have been based on the use of such assessment procedures. Furthermore, available data do not support the commonly stated hypothesis that hypnosis can create or significantly alter the clinical presentation of DID. Although some of the features of DID can be role-played, these data do not meaningfully address the etiology of any mental disorder. Criticisms of the treatment of dissociative disorders appear to be based on many misconceptions regarding how treatment is actually conducted. Patients with DID also appear to have experienced their symptoms most of their lives, well before they were ever in treatment for a dissociative disorder.

Evidence for Iatrogenesis

Prevalence of DID and Cross-Cultural Occurrence

Prevalence studies. Researchers of several studies have examined the prevalence of DID among general or specific clinical or nonclinical samples. The results of these studies (which are

summarized in Table 2), all of which were based on the use of structured interviews, suggest that DID or severe dissociative symptomatology may be much more common than was once believed.

In support of the sociocognitive model of DID, its proponents argue that the disorder may be iatrogenically created by a select group of therapists. The model's proponents cite what they state to be extreme variation in the prevalence rates for DID found in different studies as support for this position. For example, Spanos (1994) compared the finding of 3% by Ross, Anderson, Fleisher, & Norton (1991) with the finding of no cases among 89 patients by Merskey (1992; Merskey & Buhrich, 1975).

Although this argument is commonly made, given the nature of these reports, such comparisons cannot be interpreted as valid. For one reason, if different types of clinical samples are examined (e.g., individuals who have been sexually abused vs. some other specific Axis I condition), different prevalence rates may be expected. More important, Spanos (1994) was comparing systematic evaluation with opinion. Ross, Anderson, et al. (1991) used a well-validated structured interview (the DDIS) to systematically evaluate dissociative symptoms. They also used a second rater who was blind to clinical diagnoses to ensure a conservative estimate. In addition, all patients with a prior diagnosis of DID were excluded.

Merskey (1992) stated only that he had never seen a case of DID. Merskey and Buhrich (1975; which was the study cited

by Spanos) actually made no reference to DID or dissociative disorders whatsoever, illustrating only that they did not consider the diagnosis. On the basis of Merskey's description of his diagnostic procedure, he appears to have actually avoided inquiring about symptoms of DID out of fear that he would create the disorder. For example, he stated that "one patient dissociated and talked to herself in a detached fashion. In that instance the genesis of MPD was carefully avoided" (Merskey, 1992, p. 328). Although this statement is somewhat ambiguous, it appears to imply that Merskey did not ask this person anything about DID.

Most of the data used to argue that DID is rare have been of this type. In other similar reports, researchers (e.g., Chodoff, 1987; Merskey, 1992) have formerly or informally sampled clinicians and asked if they had seen a case of DID. These data all suffer from the same limitation: If the disorder is not being assessed, then one cannot make statements about its prevalence. Nakdimen (1990) noted that such data *do* demonstrate that what is indisputably rare is the clinician who ever considers the diagnosis of DID, and one can only conclude that the researchers of such reports had never seen a case with self-diagnosed or extremely obvious (atypical) DID. The hypothesis that different prevalence findings are due to the biases of the evaluators could only be tested by comparing findings from studies of similar samples where dissociative symptoms were systematically evaluated by raters with different preconceptions about DID. To date, no such study has been conducted (although see Boon & Draijer, 1993a), who included skeptical raters in their studies).

A related argument is that, independent of prevalence studies, a large number of patients with DID are being reported by a small number of clinicians (Spanos, 1994). Although it is true that clinicians who specialize in the treatment of dissociative disorders do often report having worked with a large number of patients with DID, this is not unexpected because these clinicians generally receive referrals already diagnosed as having a dissociative disorder. Cases in published reports generally come from a large number of different therapists. For example, the 100 patients with DID described by Putnam et al. (1986) were reported by 92 clinicians; the 71 cases described by Boon & Draijer (1993a) were referred from 60 clinicians; the 236 cases described by Ross, Norton, and Wozney (1989) were reported by 203 different psychiatrists; and the 355 DID cases described by Schultz et al. (1989) were reported by 355 different clinicians. Thus, the available published studies do not support the argument that only a very small number of therapists are diagnosing the majority of DID patients.

Cross-cultural evidence. Proponents of the sociocognitive model of DID also suggest that DID is a culture-bound phenomenon. Spanos (1994) listed a number of countries in which he stated that DID is supposedly rare, including France, Great Britain, USSR, Japan, and Switzerland. These data, however, suffer from the same limitation as the studies discussed above: No prevalence studies have been conducted on which to make statements regarding prevalence. The evidence cited by Spanos was opinions by clinicians or researchers or from surveys of psychiatrists (e.g., Modestin, 1992) who stated that they have never seen a case of DID or know of only a small number of cases that

Table 2
Prevalence of Patients with Dissociative Disorder (DD) and DID Among Clinical and Nonclinical Samples

Study	N	Sample	%DD	%DID
Clinical				
Ross, Anderson, et al. (1991)	299	Inpatients	20.7	3.3
Saxe et al. (1993)	110	Inpatients	13.6	3.6
Von Braunsberg (1994)	100	Inpatients (female)	20.0	13.0
Von Braunsberg (1994)	100	Forensic psychiatric (male)	22.0	17.0
Latz et al. (1995)	175	State hospital (female)	31.4	12.0
McCallum et al. (1992)	38	Eating disorder	29.0	10.0
Ross, Kronson, et al. (1992)	100	Chemically dependent	39.0	14.0
Goff et al. (1992)	100	Obsessive-compulsive disorder	10.0	0.0 ^a
Anderson et al. (1993)	51	Sexually abused	88.0	54.9
Nonclinical				
Ross (1991)	454	Community residents	11.2	1.3
Von Braunsberg (1994)	402	University students	3.5	0.5

Note. Numerals in the DD and DID columns are cases per 100 individuals. DID = dissociative identity disorder.

^a Goff et al. noted that there were three patients with dissociative disorder not otherwise specified who were "similar to MPD [multiple personality disorder]" (p. 336). A limitation to this study was that the SCID-D was administered over the phone, so the raters could not make behavioral observations. Goff et al. also noted that their assessment process may not have been sensitive enough to thoroughly evaluate these cases.

have been reported. What are needed are prevalence studies using validated assessment instruments before the true prevalence of DID in other countries can be determined.

Although no prevalence studies have been conducted outside of North America, Silva and Ward (1993) did collect objective data (using the DES) on a sample of 97 nonclinical volunteers in Great Britain. They noted that the frequency distribution of scores was remarkably similar to that found by Ross (1990) in a Canadian sample. Of the volunteers, 5% scored above 30, which is a commonly used cutoff for the presence of significant dissociative pathology. Obviously, more thorough investigations using structured interviews, such as the SCID-D, would be needed to more clearly establish the prevalence of DID in other cultures. However, the only objective data available do not support the position that severe dissociative pathology is limited to North America.

There is also a wealth of evidence suggesting that DID is in fact diagnosed throughout much of the world. Coons, Bowman, Kluft, and Milstein (1991) conducted a review of the literature on DID and found that, since 1840, DID has been reported in 21 different countries. More recently, numerous reports and a series of sound investigations of DID have come out of the Netherlands (see Boon & Draijer, 1993b, and van der Hart, 1993, for reviews). Also see Hart for an informative discussion of the political climate regarding dissociative disorders in Europe.

In a series of studies based on 82 patients with DID, Boon and Draijer (1993a, 1993b) used the SCID-D to make clinical diagnoses. The patients in the sample exhibited clinical features that were highly consistent with patients with DID that have been studied in the United States and Canada. This body of literature, none of which was cited in the recent review by Spanos (1994), demonstrates that DID is not a culture-bound phenomenon and that the disorder can be diagnosed if the symptoms are sought. The Boon and Draijer studies also illustrate how frequently clinicians miss the diagnosis of DID due to not assessing for dissociative symptoms. The majority of the Boon and Draijer patients reported that, despite their long psychiatric histories, they had never been asked about dissociative experiences.

Why the increased reporting of DID? There can be no argument that, approximately since 1980, there has been a dramatic increase in the number of diagnosed cases of DID and the number of cases that have been reported in the world literature. However, critics of the diagnosis generally do not acknowledge that there are numerous factors that logically explain and would even predict the increase in reported cases of DID, none of which rely on the iatrogenesis mechanism.

The first factor was the publication of the *DSM-III* (American Psychiatric Association, 1980), in which DID (MPD) was first included as a distinct mental disorder under a distinct section (dissociative disorders). Such a change in diagnostic nomenclature would obviously increase attention any particular disorder received. As a comparison, the disorder bulimia (now bulimia nervosa) was first included in the 1980 edition of the *DSM*, and reported cases have increased dramatically since that time.

That DID might simply have been overlooked before this

time is evident in some of the earlier literature on other mental disorders. For example, in reporting on a sample of female patients diagnosed as having either Briquet's syndrome or antisocial personality disorder, Cloninger and Guze (1970) actually noted that 8% of the patients spontaneously described themselves (to the investigators) as having a "split personality" or a "multiple personality" (p. 557). No additional comment was made about this finding, and no attempt was made to assess for DID.

A second factor that may have contributed to the increased reporting of DID is increased awareness of the reality and prevalence of child abuse. Kluft (1994) noted that, until recently, reports of sexual abuse were routinely dismissed as fantasy and that, as recently as 1975, psychiatric textbooks were stating that incest occurred in 1 out of 1 million families. Clinicians are now willing to listen to their clients and not dismiss allegations and symptoms as hysteria or fantasy. Over the past 15 years, there has also been a dramatic increase in research on the effects of child abuse (Briere & Runtz, 1991; Browne & Finkelhor, 1986; Trickett & Putnam, 1993). It would seem understandable that increased attention to the sequelae of child abuse would lead to increased attention to one particular sequela of more severe child abuse.

A third factor was the Vietnam War and the subsequent increased interest in PTSD. The body of research that followed drew attention to the effects of trauma on adults but also brought the recognition that the same set of symptoms exists in individuals exposed to civilian trauma including rape (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992) and child abuse (Rowan & Foy, 1993). Many of the symptoms of PTSD (e.g., flashbacks, depersonalization, and emotional numbing) are now recognized as clearly dissociative in nature, and many clinical researchers have made a strong argument that DID should be conceptualized as a form of childhood-onset PTSD (e.g., Spiegel, 1991, 1993).

A fourth factor has been the developments in the field of cognitive psychology, such as network models of memory and information processing. Rumelhart and McClelland's (1986) parallel-distributed processing is an example. Carson and Butcher (1992) noted that the evidence of dissociative memory subsystems seen in DID is analogous in some ways to computer multitasking, and Sternlicht, Payton, Werner, and Rancurello (1989) noted that DID can receive a very plausible legitimization within the framework of cognitive psychology. Research on these cognitive models has led to integrative proposals that explain the dissociative disorders in terms of such models (e.g., Li & Spiegel, 1992; Spiegel, 1990; Yates & Nasby, 1993).

A final factor may simply be a recent possible trend toward lessened skepticism regarding DID. A recent study by Hayes and Mitchell (1994) clearly illustrates that skepticism regarding DID may predict accuracy with which it can be diagnosed. They first objectively measured the degree of skepticism regarding DID in a group of mental health clinicians (psychiatrists, psychologists, and social workers). The clinicians were then presented clinical vignettes of a patient with either DID or schizophrenia. The creation of the vignettes was guided by the *DSM-III-R* (American Psychiatric Association, 1987) descriptions of the symptomatology and essential features of each disorder,

and the credibility of each was ensured by a panel of experts in each field. Overall, an accurate diagnosis of DID was made by only 22% of the clinicians (compared with 54% for schizophrenia). There was only one false-positive diagnosis of DID (a clinician who rated the patient in the schizophrenia vignette as having DID). Thus, false-negative diagnoses of DID far outweighed the false positives. Perhaps most critically, skepticism about DID predicted diagnostic inaccuracy.

It is certainly possible that some of the recently reported cases of DID have been false-positive diagnoses, made by untrained or overzealous practitioners. However, such diagnostic errors are also likely to occur with any psychiatric disorder. Given the findings by Hayes and Mitchell (1994), as well as that dissociative patients are frightened to disclose their symptoms, such symptoms are not included in standard mental status examinations, and most practitioners may not screen for or even know how to screen for dissociative disorders, it seems unwarranted to conclude that the false-positive diagnoses of DID outweigh the false negatives.

Has the Disorder Changed Over Time?

In support of the sociocognitive model of DID, some of its proponents (Merskey, 1992; Spanos, 1994) suggest that there have been marked changes in the symptomatology of DID over time. The features that have allegedly changed are the number of alters and the association with childhood trauma. According to Merskey and Spanos, the number of alters has allegedly increased and the association with childhood trauma has only recently developed.

The average number of alters described in written reports may have increased (North et al. 1993). However, early reports were based on the number of alters that were spontaneously reported by the patient, whereas later reports been based on active assessment on the part of the clinician or researcher; thus, the numbers are not directly comparable. The average number of alters reported at the time of diagnosis has apparently remained consistent over time (Ross, Norton, & Wozney, 1989). Although one could argue that the assessment process is creating new alters, more recent data on the character of DID patients suggest an alternative interpretation may be more parsimonious. Given that patients with DID frequently appear to be avoidant and distrustful (Ellason et al., in press; Kluft, 1991a) and report being extremely afraid and ashamed of their dissociative symptoms (Cohen et al., 1991), it seems highly unlikely that such individuals would be likely to spontaneously volunteer all aspects of their dissociative symptomatology.

For the same reason, it would be unwarranted to assume that patients with DID would be likely to spontaneously report having been sexually abused. One would have to make this assumption to conclude that the association between DID and abuse has recently developed because the data for such a conclusion are a few early case reports in which patients did not spontaneously report histories of abuse (see Spanos, 1994). Recent data suggest that individuals with documented abuse histories are often unlikely to report such histories for several possible reasons (Femina, Yeager, & Lewis, 1990; Williams, 1994). The cases to which Spanos referred (from the early part of the 20th

century) were also reported during a time period when incest was believed to be almost nonexistent, routine inquiries were not made, and reports were often not believed or were interpreted as fantasy (Bowman, 1990; Olafson, Corwin, & Summit, 1993), making it even less likely that abuse would be reported or recognized.

A more parsimonious interpretation of the data regarding DID and childhood trauma is that the *recognition* of the association is relatively new. Similar conclusions were reached by Carlson and Butcher (1992) who noted that "while it is somewhat amazing that this connection [between DID and childhood trauma] was not generally recognized until about 1984, there is now no reasonable doubt about the reality of this association" (p. 208). The data that support such conclusions regarding the association between DID and childhood trauma are discussed in detail below (see Child Abuse and DID).

In summary, there remains a lack of data that strongly suggest that iatrogenic factors have been at work in the creation of alteration of DID. More research is needed on the prevalence of DID and other dissociative disorders before their true prevalence can be determined. However, researchers who have systematically evaluated the conditions have found them to be relatively common among general clinical and nonclinical samples. In the reports of low prevalence, researchers did not screen for or assess dissociative symptoms. Thus, the wide range in prevalence estimates can be parsimoniously explained by whether the disorder was assessed. The same can be said for cross-cultural studies. A number of factors quite parsimoniously explain the recent increases in the reporting of DID, none of which are based on the hypothesis that the disorder is being created iatrogenically or overdiagnosed any more than any other psychiatric disorder. No conclusive data suggest that the disorder has changed over time, either.

Child Abuse and DID

Researchers of recent studies have consistently found a strong association between DID and forms of childhood trauma. Patients have been found to almost invariably report some form of childhood trauma, most commonly physical abuse, sexual abuse, or both (see Table 3). The abuse reported by individuals with DID is often severe, extensive, and sadistic (Kluft, 1985; Putnam, 1989; Wilbur, 1984). See Kluft (1985, 1994) for illustrative case examples. Other forms of childhood trauma have also been reported including neglect, abandonment, wartime experiences, seeing one's parents or sibling killed, near death experiences (e.g., near drowning), and painful medical procedures (Coons et al., 1988; Kluft, 1984; Putnam, 1989; Ross, Norton, & Wozney, 1989).

In two of these studies, the investigators also systematically evaluated whether the patients with DID met the criteria for PTSD. Boon and Draijer (1993a) reported that 81% of the patients in their sample met the PTSD criteria, and Ellason et al. (in press) diagnosed PTSD in 79% of the patients in their sample. J. W. Ellason (personal communication, October 7, 1994) reported that, of the patients who did not meet the full PTSD criteria, all endorsed some of the criteria.

Several recent studies have also demonstrated a general rela-

Table 3
Percentages of Patients With DID and Reported Histories of Trauma, Abuse, or Both

Study	N	Sexual	Physical	Sexual or physical	No trauma
Putnam et al. (1986)	100	83.0	75.0	NR	3.0
Coons et al. (1988)	50	68.0	60.0	96.0	NR
Ross, Norton, & Wozney (1989)	236	79.2	74.9	88.5	NR
Ellason et al. (in press)	135	92.3	90.0	96.2	NR
Ross et al. (1990)	102	90.2	82.4	95.1	NR
Schultz et al. (1989)	355	86.0	82.0	NR	2.0
Boon & Draijer (1993a)	71	77.5	80.3	94.4	NR

Note. DID = dissociative identity disorder; NR = not reported.

tionship between trauma (of various types) and dissociative symptoms (Branscomb, 1991; Cardena & Spiegel, 1993; Chu & Dill, 1990; Freinkel, Koopman, & Spiegel, 1994; Herman, Perry, & Kolk, 1989; McCann, Sakheim, & Abrahamson, 1988; Putnam, Helmers, Horowitz, & Trickett, 1995). Furthermore, many of the core phenomena of (and diagnostic criteria for) PTSD are dissociative symptoms (e.g., flashbacks, emotional numbing, and inability to remember the trauma), and some patients with severe PTSD have been found to also have full-blown dissociative disorders (Brende, 1987). Researchers have also been able to differentiate DID from less severe dissociative disorders on the basis of severity and extent of childhood trauma (Ross, Anderson, et al., 1992). These types of data further support the position that the most severe of the dissociative disorders (DID) is posttraumatic in origin.

Recently, supporters of the sociocognitive model of DID have argued that, despite the data noted above, there is not a connection between DID and child abuse (Frankel, 1994; Ofshe & Watters, 1993; Spanos, 1994; Spanos & Burgess, 1994). These researchers do not seem to address the study of the relationship between dissociation and various forms of trauma or the significance of the dissociative symptoms associated with PTSD. They also do not deny that research has found patients with DID to almost invariably report histories of childhood trauma. Rather, these researchers argue that reports made by patients with DID are false or that any association between trauma and DID is merely coincidental.

Regarding the latter argument, Spanos (1994) pointed to the correlational nature of the data, noting that such data do not allow one to make causal inferences. That the data are correlational is certainly true because ethical limitations would not allow for experimental studies of the effects of sexual abuse, physical abuse, or both of children. For the same reason, the empirical support for the relationship between PTSD and trauma is also correlational. However, such a state of affairs would not seem to be a convincing argument that PTSD is not a posttraumatic condition.

The argument that the abuse reports should not be believed takes many forms, but most revolve around the concept of iatrogenesis. Frankel (1994) argued that the memories should be doubted because they are adult reconstructions of childhood experiences, which (he stated) are subject to major distortion. However, in a recent review of psychopathology and retrospec-

tive reports of early experience, Brewin, Andrews, and Gotlib (1993) concluded that the available data do *not* support an extreme reconstructive model of memory. They concluded that, although memory (especially that for peripheral details) is clearly less than perfect, "the evidence supports the view that adults asked to recall salient factual details of their own childhoods are generally accurate, especially concerning experiences that fulfill the criteria of having been unique, consequential, and unexpected" (Brewin et al., 1993, p. 87). They further noted that even reconstruction theorists are modest about the degree of reconstruction that occurs and cited Barclay's (1986) statement: "It is not the case . . . that the meaning around which autobiographical memory is organized is a complete fabrication of life events. There is a fundamental integrity to one's autobiographical recollections" (p. 97).

Another form of the iatrogenic argument is that memories have been suggested by psychotherapists through the use of hypnosis (Frankel, 1994; Spanos, 1994). This argument rests largely on the assumption that hypnosis is frequently used to retrieve memories of abuse (Frankel, 1994; Spanos, 1994). However, the cases in the large reports of patients with DID cited earlier (e.g., Coons et al., 1988; Putnam et al., 1986; Ross et al., 1990) came from numerous sources with widely varying therapy experiences. Across all studies, a vast number of the patients had not had exposure to hypnosis at the time the abuse was reported. As noted above, only two of the patients reported by Coons et al. had been subjected to hypnosis, and 100% of the patients reported histories of trauma (96% from childhood).

Exposure to hypnosis also does not imply that it was used for memory retrieval because many commonly recommended uses of hypnosis for patients with DID are for purposes other than memory retrieval (e.g., Kluft, 1982). Furthermore, Putnam et al. (1986) found that there were no differences in the reported childhood histories of patients treated or not treated with hypnosis. Ross and Norton (1989) found slight differences in similar samples; however, the majority of the patients who had never been hypnotized did report some form of childhood abuse.

Critics of the posttraumatic model of DID argue that lack of corroboration of the abuse is the most critical reason why the reports should not be believed (Frankel, 1994). In his review, Frankel noted that most published research studies had not reported attempts to corroborate the abuse reports. Although

corroborating evidence would strengthen the argument that the abuse occurred, assuming and communicating to the patient that the report cannot be believed unless one can prove it is somewhat troublesome because it implies a basic lack of respect for the client's account and is also the same message that perpetrators of abuse generally communicate to those they abuse. The American Psychiatric Association Board of Trustees (1994) also recently cautioned that such expression of disbelief is likely to cause the patient further pain and decrease his or her willingness to continue treatment.

Perhaps most important, when attempts have been made to corroborate reports that patients with DID were individuals who experienced child abuse, the attempts have generally been successful. Coons and Milstein (1986) reported being able to obtain corroborating evidence (from either data from other family members or emergency room visits) in 17 out of the 20 cases in their sample. More recently, Coons (1994) examined a group of child and adolescent patients with either DID ($n = 9$) or DDNOS ($n = 12$). By examining available records (e.g., from child protective services and police), they were able to corroborate the abuse in all but one of the patients with DID and in all of the patients with DDNOS. In anecdotal cases, the physical evidence for the reality of the abuse is frequently overwhelming (Bowman, Blix, & Coons, 1985), and there have also been no cases reported in the scientific literature where the alleged abuse in a patient with DID was found to be totally fabricated.

In summary, there does not appear to be any convincing reason to doubt the association between DID and childhood trauma. Recent research has found patients with DID to almost invariably report histories of childhood trauma, and attempts to corroborate the abuse have been successful. Dissociative symptoms (the core psychopathology of DID) also appear to be clearly associated with traumatic experiences (and PTSD), and the majority of patients with DID also appear to have diagnosable PTSD. This conclusion is not to imply that memory is infallible or that every detail of memories reported by patients with DID should be assumed to be accurate. However, finding parts of a story reported by an individual with DID that appear distorted or that cannot be corroborated is not convincing evidence that an entire abuse history should be discounted or interpreted as fantasy.

Concluding Comments on Iatrogenesis and DID

I conclude that the sociocognitive model of the etiology of DID is fundamentally flawed and lacking in support. Reasons for this conclusion are as follows: (a) The model is based on numerous incorrect assumption about DID regarding its core psychopathology, clinical presentation, assessment, and currently recommended treatment; (b) much of the data that has been presented cannot address the issue of etiology of any mental disorder; (c) many of the inferences that have been made from available data are invalid; and (d) there is evidence that directly disconfirms the model that has not been addressed by its proponents.

It may be important to consider issues of secondary gain, malingering, or shaping influences due to demand characteristics

of therapy when evaluating some cases of DID. However, there is currently no empirical or logical support for the position that these issues should be of more concern for the assessment and treatment of DID than for any other psychiatric disorder. Thus, I recommend that the sociocognitive model be abandoned as an etiological explanation of DID.

This conclusion is not meant to imply that iatrogenesis is not an important variable to consider in the treatment of dissociative disorders. It seems to be a common perception among skeptics of DID that practitioners who treat patients with dissociative disorders are not concerned with the issue of iatrogenesis. However, such a perception appears to be inconsistent with the available literature. For example, an early edition of the journal *Dissociation* (Vol. 2, No. 1) was devoted entirely to the topic of iatrogenesis, and clinicians and researchers have readily noted that treatment can have numerous iatrogenic effects. Additional alters can be iatrogenically created (Kluft, 1989), patients can be overwhelmed by premature attempts to process trauma memories (Fine, 1991), and patients' perceived separateness can be worsened by treating alters differently and as if they are different people (Kluft, 1993). The reality of these possible iatrogenic effects of treatment all illustrate the need for clinicians to have adequate training, supervision, or both before attempting to treat a patient with DID.

However, proponents of the sociocognitive model of DID argue that no specialized training or treatment is necessary because patients' dissociative symptoms should be ignored (e.g., McHugh, 1993; Spanos, 1994). There now seems to be clear data suggesting that such a strategy is ineffective. As noted above, most diagnosed patients with DID have had their dissociative symptoms ignored by mental health professionals (for an average of 7 years) and the "benign neglect" of their symptoms has not led to clinical improvement. Although there have been no controlled outcome studies, several reports of large numbers of cases have shown that patients can recover within a period of 2 to 4 years when their dissociative condition is treated (Coons, 1986; Kluft, 1984, 1986; Ross & Dua, 1993).

These data seem to suggest that, for at least a large number of patients with DID, nonspecific treatment—which implies that the dissociative disorder was not addressed—does not lead to improvement in their condition and that appropriate treatment can lead to recovery. These data also question the frequently made argument that therapists extend therapy by making the diagnosis of DID (e.g., Aldridge-Morris, 1989; McHugh, 1993; Ofshe & Watters, 1993). In actuality, the data suggest that *not* making the diagnosis of DID and *not* treating the dissociative disorder may be more likely to extend the treatment, possibly indefinitely. Greaves (1989) referred to such nontreatment of a patient's treatable condition as *iatrogenesis by neglect*. More research is clearly needed to truly evaluate the recommended treatment for DID; however, a wealth of data suggest that ignoring the problem is not the answer.

Directions for Future Research

If the sociocognitive model of DID is to be abandoned, then where do researchers go from here? Two directions seem most critical: (a) education and (b) continued research. Because

the vast majority of the research on DID has been conducted and published only within the past few years, many people within the fields of psychology and psychiatry remain unfamiliar with this body of recent research. Furthermore, because a lack of knowledge about DID was recently found to be significantly associated with skepticism about the disorder (Hayes & Mitchell, 1994), education may be the most effective means of combating lingering skepticism and allowing the continuation of research. As Fraser (cited in Klein, Doane, & Curtis, 1994) noted "the research won't flourish if everyone is skeptical of it [DID]. It will flourish if it is recognized as an important clinical problem and equally important, a new avenue to the study of the mind" (p. 3).

The research has indeed begun to flourish, but many questions remain. In terms of the etiology of DID, it is now known that there is strongest support for the posttraumatic model. Persons with DID appear to have almost invariably experienced some form of childhood trauma, dissociative symptoms are reliably associated with traumatic experiences, and the majority of patients with DID also appear to have PTSD. However, the exact nature of the association between DID and childhood trauma is unclear. It has yet to be determined why some individuals develop DID, whereas others do not. The existence of an inherited predisposition has been hypothesized but requires further empirical study, as does the question of the relative causal significance of childhood trauma (or abuse) per se versus the abusive family environment in which the trauma occurs.

It is also now known that DID, as well as dissociative symptoms in general, can be reliably assessed when the appropriate methods are used. Structured interviews and objective self-report instruments are most appropriate for assessment purposes (Carlson & Armstrong, 1994). However, a florid, obvious presentation of the disorder is atypical, and persons with the condition often make efforts to conceal their symptomatology out of fear of being labeled *crazy* or of general distrust of others.

DID also appears to have a stable set of features generally distinguishing it from most other mental disorders. The highest degree of symptom overlap may occur with other dissociative disorders and with PTSD, which is not surprising considering the apparently similar posttraumatic etiology of these conditions. Indeed, in the future, researchers should examine whether DID and other forms of dissociative disorders would be best conceptualized as a form of PTSD.

The prevalence of DID appears to be much higher than was once believed. Studies conducted to date suggest that the disorder may be approximately as common as anorexia nervosa or schizophrenia. However, additional large-scale epidemiological studies are needed to more clearly determine the prevalence of the condition among the clinical and nonclinical population. Currently, there is no empirical support for the position that DID is an extremely rare condition.

Much more research is needed on examining the effectiveness of various treatment approaches for DID. Evidence does not support the position that the disorder will spontaneously remit if untreated. The recommended treatment for DID in the dissociative disorders treatment literature is actually similar to that for PTSD, in that exposure to memories of the trauma is a crit-

ical component. Although some preliminary data suggest that this approach can be effective for many persons with DID, much more controlled research is needed.

Finally, what researchers now know about the capacities of the human mind, as well as the realities and tragic consequences of child abuse, should help psychologists in realizing that DID need not be perceived as an unbelievable phenomenon. Perhaps continued education and research in these areas may also help to continue to demystify DID and dissociative phenomena (Klein et al., 1994). Ross (1989) wrote, "What is MPD? MPD is a little girl imagining that the abuse is happening to someone else" (p. 72). Although this definition may not capture all of the complexity of dissociative disorders, perhaps Ross was right that one should not lose sight of the basic simplicity of this model. DID should remind one of the tragedy of child abuse as well as the creative ability of the human mind to survive in the face of adversity.

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