Multiple Personality Disorder

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Multiple personality disorder (MPD), currently known as dissociative identity disorder in the American Psychiatric Association's official diagnostic manual of mental disorders, has long been among the most controversial diagnoses in psychology and psychiatry. Although the precise diagnostic criteria for MPD have shifted somewhat over the years, it is now defined as a condition characterized by the presence of two or more distinct personalities or personality "states" (that is, temporary patterns of behavior) that recurrently assume control of the individual's behavior. Such alternate personalities or personality states, which are called "alters," frequently exhibit personality features that differ markedly from those of the primary, or "host," personality. For example, if the primary personality is shy and retiring, one or more of the alters are often outgoing or flamboyant. In addition, individuals with MPD report significant episodes of amnesia (memory loss) in regard to important personal information. For example, they may report frequent hours or days of "lost time": they cannot recall where they were or what they were doing in those periods. This amnesia is commonly reported to be asymmetrical, whereby the primary personality knows little about the behaviors of the alters but not vice versa (American Psychiatric Association 1994). Most MPD patients are women, although the reason for this imbalanced sex ratio is unknown.

The nature and features of MPD alters are highly variable both across and within individuals. The number of alters has been reported to range from one (in the so-called split personality) to hundreds or even thousands, with one clinician reporting a case of an MPD patient with 4,500 alters (Acocella 1999). These alters are not uncommonly of different sexes, ages, and even races. There have even been reported alters of Mr. Spock, lobsters, chickens, gorillas, unicorns, God, and the bride of Satan (Acocella 1999). In addition, alters have been purported to differ in their allergies, handwriting, voice patterns, and eyeglass prescriptions.

Reports of MPD in both popular and clinical literature date back at least to the nineteenth century. Robert Louis Stevenson's classic 1885 book, *The Strange Case of Dr. Jekyll and Mr. Hyde,* which describes a scientist who ingests a mysterious potion that transforms him into an entirely different individual, is among the first tales reminiscent of the modern-day notion of MPD. Although the remarkable symptoms of MPD captured the imagination of authors and researchers throughout the nineteenth and twentieth centuries, reports of this condition were exceedingly rare until the late twentieth century. As of 1970, there were a total of 79 cases of clear-cut

John Barrymore starring in *Dr. Jekyll and Mr. Hyde.* (Underwood & Underwood/CORBIS)

MPD in the world literature. One of these was the celebrated case of Chris Sizemore, which formed the basis of the book (and later the Hollywood film) *The Three Faces of Eve* (Thigpen and Cleckley 1954). As of 1986, however, the number of reported MPD cases had swelled to approximately 6,000. This massive increase coincided closely with the release of the popular nonfiction book *Sybil* (Schreiber 1974), which told the story of a young woman with sixteen personalities who reported a history of severe and sadistic child abuse. This best-selling book was turned into a widely viewed television film in 1977. The number of reported cases of MPD at the turn of the twenty-first century is difficult to estimate, although it appears to be in the tens of thousands (Acocella 1999). The reasons for this apparent "epidemic" in the number of MPD cases is unknown, and, as we will see shortly, it remains a point of considerable debate.

It is also worth noting that the number of MPD alters has increased markedly over time. Whereas most cases of MPD prior to the 1970s were characterized by only one or two alters, recent cases are generally characterized by considerably more (North et al. 1993). A 1989 study, for example, reported that the mean number of MPD personalities was sixteen, which was precisely the number reported by Sybil (Acocella 1999).

The causes of MPD have been a source of heated and at times acrimonious disagreement among researchers. Colin Ross (1997) and others have proposed that MPD is a "posttraumatic" condition that arises primarily from a

history of severe physical and/or sexual child abuse. Ross maintained that individuals who experience horrific abuse in early life often "dissociate" (hence, the term *dissociative identity disorder*) or compartmentalize their personalities into distinct alters as a means of coping with the profound emotional pain of this trauma. According to Ross (1997, 59), "MPD is a little girl imagining that the abuse is happening to someone else." In support of this assertion, proponents of the posttraumatic model cite data suggesting that a large proportion (perhaps over 90 percent) of individuals with MPD report a history of child abuse (Gleaves 1996).

Proponents of the posttraumatic model attribute the dramatic recent increase in the reported prevalence of MPD to the heightened awareness and recognition of this condition by psychotherapists. Specifically, they argue that clinicians have only recently become attuned to the presence of possible MPD in their clients and, as a consequence, now inquire more actively about potential symptoms of this condition (Gleaves 1996). In many cases, these proponents advocate the use of hypnosis, sodium amytal (so-called truth serum), guided imagery, and other suggestive therapeutic techniques to "call forth" alters that are otherwise inaccessible, as well as to recover apparent memories of child abuse that have seemingly been repressed.

Although the posttraumatic model of MPD remains popular among many psychotherapists, numerous critics have called its core assumptions into question. The most influential alternative model of MPD is the sociocognitive model advanced by Nicholas Spanos (1994). According to this model, MPD is largely a socially constructed condition that results from inadvertent therapist cueing (e.g., suggestive questions regarding the existence of possible alters), media influences (e.g., film and television portrayals of MPD), and broader sociocultural expectations regarding the presumed features of MPD. Specifically, Spanos and his colleagues contended that individuals with MPD are engaged in a form of role-playing that is similar in some ways to the intense sense of imaginative involvement that some actors report when performing in a part. Because individuals who engage in role-playing "lose themselves" in the enacted part, this phenomenon should not be confused with simulation or conscious deception. Advocates of the sociocognitive model do not believe that most individuals with MPD are consciously faking this condition, although there is compelling evidence that at least a few well-publicized criminals (e.g., serial murderer Kenneth Bianchi) have attempted to fake MPD. Instead, according to the sociocognitive model, the symptoms of MPD are almost always genuine, but they are induced primarily by suggestive therapeutic practices and expectations regarding the features of the disorder. Moreover, according to this model, the dramatic "epidemic" in MPD cases since the 1970s stems not from improved diagnostic and assessment practices but rather from iatrogenic (therapist-induced) influences and the increased media attention accorded MPD.

Advocates of the sociocognitive model invoke a variety of pieces of evidence in support of this position (see Lilienfeld et al. 1999; Spanos 1994). For example, a large proportion and perhaps even a substantial majority of MPD patients exhibit few or no unambiguous signs of this condition (e.g., alters) prior to psychotherapy. Moreover, patients with MPD are in psychotherapy an average of six to seven years before being diagnosed with this condition (Gleaves 1996). These pieces of evidence raise the possibility that such patients developed unambiguous MPD symptoms only after receiving treatment.

In addition, the distribution of MPD cases across therapists appears to be strikingly nonrandom. For example, a 1992 study in Switzerland revealed that 66 percent of MPD diag-

noses were made by .09 percent of clinicians (Spanos 1994; see Lilienfeld et al. 1999, for other examples). Such findings could perhaps be explained by positing that patients with actual or possible MPD are selectively referred to MPD experts. Nevertheless, they are also consistent with the suggestion that only a handful of clinicians are diagnosing and perhaps eliciting MPD in their patients.

Although the MPD epidemic is relatively recent, a number of other psychopathological "epidemics" have been observed throughout history. Indeed, there is suggestive evidence that the overt manifestations of so-called hysteria have shifted substantially over time in accord with prevailing sociocultural beliefs and expectations. For example, Victorian England in the nineteenth century witnessed a dramatic upsurge in the incidence of certain unexplained somatic symptoms, such as paralyses and aphasias (inability to speak) that lacked a demonstrable physical basis. These symptoms were subsequently displaced by less florid symptoms of fainting ("the vapors"; see Veith 1965). Proponents of the sociocognitive model contend that the recent epidemic of MPD is merely one manifestation of the capacity of sociocultural expectations to induce the large-scale transmission of certain conditions (see also Showalter 1997). This hypothesis is difficult to test but merits careful scientific consideration.

Still other evidence provides indirect support for the sociocognitive model. For example, many standard therapeutic practices for MPD appear to reward patients' displays of multiplicity and encourage the emergence of alters (Lilienfeld et al. 1999; Piper 1997). Some of these practices appear to be highly suggestive. Frank Putnam (1989), for example, recommended using a technique known as the "bulletin board," which encourages MPD alters to post notes to one another. Ross advocated giving names to alters to affirm their existence, and he used a technique known as the "inner board meeting" to "map" the system of alters and recover repressed memories: "The patient relaxes with a brief hypnotic induction, and the host personality walks into the boardroom. The patient is instructed that there will be one chair for every personality in the system. . . . Often there are empty chairs because some alters are not ready to enter therapy. The empty chairs provide useful information, and those present can be asked what they know about the missing people" (Ross 1997, 351). These and other techniques may inadvertently "reify" alters and encourage patients to view different aspects of their personalities as entirely distinct entities.

Moreover, some psychotherapists regularly use hypnosis and other suggestive techniques in efforts to unearth presumed latent alters and memories of past abuse. Nevertheless, there is consistent evidence that hypnosis does not enhance memory and instead may often lead to false memories (that is, memories of events that never occurred), although it typically increases individuals' subjective confidence in their memories (Lynn et al. 1997).

It is important to emphasize that the sociocognitive model does not assert that MPD symptoms arise in a vacuum. There is compelling evidence that many individuals with MPD enter psychotherapy with a host of psychological difficulties, including depression, anxiety, interpersonal difficulties, and symptoms of eating disorders. In particular, a large proportion (perhaps 50 percent or more; see Lilienfeld et al. 1999) of individuals with MPD in clinical samples meet diagnostic criteria for borderline personality disorder (BPD), a condition characterized by such symptoms as unstable identity, dramatic and seemingly inexplicable mood swings, impulsive and self-damaging behaviors (e.g., cutting oneself), and dramatic shifts in one's attitudes toward people (e.g., alternating between worshiping and devaluing the same individual within a short span of time). Advocates of the posttraumatic

model typically maintain that the extensive overlap between MPD and BPD actually reflects the fact that many BPD patients suffer from "latent" (undiagnosed) MPD. But another and perhaps more plausible interpretation is possible. Specifically, individuals who enter psychotherapy with multiple BPD features may be seeking an explanation for their seemingly inexplicable instability in self-concept, mood, and impulse control. A therapist who repeatedly prompts such individuals with suggestive questions (e.g., "Might there be a part of you to whom I haven't yet spoken?") or encourages clients to search for dissociated alters may be especially likely to elicit reports of indwelling "identities" that can ostensibly account for these individuals' puzzling behaviors (see Ganaway 1995).

A final important source of evidence in support of the sociocognitive model is the fact that MPD is largely a culture-bound syndrome. Until quite recently, MPD was diagnosed almost exclusively in North America (Spanos 1994). Interestingly, however, MPD has recently begun to be diagnosed with considerable frequency in certain European countries, such as the Netherlands, where several prominent MPD proponents have sparked public interest in the condition. In addition, several psychiatric disorders bearing intriguing similarities to MPD have been observed in non-Western countries. For example, some women in Malaysia and Indonesia suffer from a condition known as "latah," which is marked by sudden and short-lived episodes of profanity, trancelike states, and command obedience (responding automatically to others' suggestions), followed by amnesia for the episode. Some men in Malaysia and certain other countries (e.g., Laos) exhibit a condition known as "amok," which is marked by a period of intense brooding in response to a perceived insult, followed by a dramatic outburst of uncontrolled and extremely aggressive behavior toward others (hence, the phrase *running amok*). The episode is often followed by amnesia for what transpired. Although the underlying commonalities among MPD, latah, amok, and similar conditions (see American Psychiatric Association 1994) remain to be clarified, the possibility that these conditions are superficially different cross-cultural manifestations of the same underlying disorder is intriguing.

Finally, Spanos (1994) and other critics (e.g., Lilienfeld et al. 1999) have challenged a core assumption of the posttraumatic model, namely, the presumed relation between child abuse and subsequent MPD. Almost all of the findings on the child abuse–MPD association are based on retrospective memory reports that have not been corroborated by objective evidence (e.g., documented records of abuse). Because psychologists have long known that retrospective reports are often subject to memory distortion, such reports must be interpreted with considerable caution. Rendering these reports even more problematic is the fact that they typically derive from MPD patients who have been in psychotherapy for years. Because many of these patients have been subjected to hypnosis and other suggestive procedures that are known to increase the occurrence of false memories, their reports of past child abuse should not be accepted without external corroboration. These methodological limitations do not refute the claim that child abuse is associated with and perhaps even causally related to MPD in certain cases. But they indicate that the data supporting this claim are less convincing than has often been claimed. Interestingly, prior to the publication of *Sybil* in 1974, reports of past child abuse among MPD patients were very rare. This intriguing but often overlooked fact is consistent with the possibility that the marked increase in child abuse reports among MPD patients is largely a function of therapists' use of suggestive procedures to recover memories of abuse.

At the present time, the data do not allow an impartial observer to definitively choose be-

tween the posttraumatic and sociocognitive models of MPD. Nevertheless, the powerful convergence across several independent lines of evidence provides compelling support for many aspects of the sociocognitive model. Indeed, even many proponents of the posttraumatic model now acknowledge that a certain number of MPD cases are likely to be largely iatrogenic in origin. It is conceivable that both models are at least partly correct. For example, perhaps an early history of child abuse leads certain individuals to adopt a fantasy-prone personality style as a means of coping with this trauma. This personality style may, in turn, increase individuals' susceptibility to suggestive therapeutic procedures, leading to the induction of alters. This and even more sophisticated models of MPD have yet to be subjected to direct empirical tests.

Nevetheless, the recent MPD epidemic imparts one clear and crucial lesson: beliefs can help to shape reality. Psychotherapists must therefore remain cognizant of the possibility that their therapeutic practices can inadvertently exacerbate and perhaps even cause psychopathology.

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