progresses. It was most obvious in her marriage; she had gained an extraordinary ability to say "no" to destructive patterns in favour of the constructive possibilities.

Comments

From the perspective of dissociation/integration, the three years of therapy had uncovered repressed experiences, loosened up Marie's dissociative barriers, integrated parts of herself and contributed to positive outcomes in her marital, professional and social relations. Regarding the fact that during the last two years of therapy the frequency had been only one session a month, Marie had progressed relatively quickly from saying: "I didn't know I had a shadow" to being the one who was in charge of her own therapy, knowing what she needed for healing her inner child and using her protective part in a less energy-consuming manner.

An interesting question is: If I had ignored the signs of dissociative defenses in favour of the theory of neurotic, borderline or psychotic diagnosises, how would I have understood her nightmare anxieties? If I had relied on insight and working through resistance and transference reactions as therapeutic tools or if I had relied on home assignments, suggestions and metaphoric interventions, would I have reached her? How long would it have taken? Or would she, like "Marge" in Irvin Yaloms (1989) *Love's Executioner*, be only partially helped, namely the part accepted by the therapist as the real patient?

References

Watkins, J.G. (1971). The affect bridge: A hypnoanalytic treatment. International Journal of Clinical and Experimental Hypnosis, 19, 21-27.

Watkins, J.G. & Watkins, H.H. (1992). A comparison of "hidden observers," ego states and multiple personalities, Hypnos, XIX, 4-92

Yalom, I.D. (1989). Love's executioner. London: Penguin books.

© M.E.G. Stiftung

Dissociative Identity Disorder: Perspectives on Recent Findings and Current Controversies

Richard P. Kluft

■ *Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), has been surrounded with controversy throughout its history. This contribution explores several issues concerning DID that are of interest to modern clinicians and scientific investigators. The recent history of DID will be reviewed, current thoughts about its etiology (inluding trauma, iatrogenesis, and factitious symptom formation) discussed, and the historical accuracy of alleged traumata studied. Also, the effects of specific treatment interventions will be compared to the impact of therapies that do not address core DID phenomena. The benefits and liabilities of specialized dissociative disorders programs will be explored, and the role of hypnosis in the treatment of DID will be outlined.*

Introduction

Controversy is no stranger to the study of Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD). It tends to evoke polarized responses of fascination or skepticism, neither of which is associated with objectivity or clarity of insight. Enthusiasts and the doubters alike, armed with unacknowledged confirmatory bias (Baron, Beattie, & Hershey, 1988) and motivated skepticism (Ditto & Lopez, 1992), tend to survey the dissociative disorders field with an inclination to search for material and potential interpretations that confirm their points of view and/or disparage their opponents' perceptions instead of attempting to discover all available evidence and assess it evenhandedly. Invariably, they confirm their original hypotheses, and declare their opponents to be incorrect and/or misguided, and deny them credibility.

As an illustration, we may turn to a recent article by Frankel (1992) challenging the allegations of childhood traumatization made by DID/MPD patients. Frankel states few articles document alleged abuses. Yet Frankel fails to cite several articles in which abuse has been documented, particularly in childhood cases. Likewise, Fahy (1988) adds Kluft to the list of those who caution against the use of hypnosis for DID/MPD.

Kluft has cautioned against the inappropriate use of hypnosis, but has authored dozens of articles in which he advocates the circumspect use of hypnosis with this group of patients.

In addition, cognitive dissonance theory (Festinger, 1957) teaches us that when we hold a belief strongly and encounter information that disconfirms it, we are more likely to discard the disconfirmatory evidence than the theory that we cherish. Therefore, it is not uncommon for adherents of one point of view to systematically disregard and/or dismiss data that is inimical to their original points of view.

We know through the seminal work of Thomas Kuhn (1970) that in science we tend to view the world through a series of paradigms, which replace one another as we subscribe to successive views of the world. When scientists view the world under the influence of a new paradigm they see new and different things, even if they are examining familiar subjects with familiar instruments. In fact, Kuhn states, "In so far as their only recourse to that world is through what they see and do, we may want to say that after a revolution [shift of paradigms] scientists are responding to a different world" (1970, p. 111). "The proponents of competing paradigms ... see different things when they look from the same point in the same direction. Both are looking at the world, and what they look at has not changed. But in some areas they see different things, and they see them in different relations to one to the other" (1970, p. 150). We should not be surprised to find that many of the most vehement skeptics with regard to DID/MPD are very senior persons who had long and distinguished careers before the rise in the mid-1980s of what Loewenstein has described as the "'Wilburian Revolution' in the understanding of MPD" (Loewenstein, 1993, p. 52); i.e., the understanding of DID/MPD as a complex dissociative process with the potential of having a complex system of alters, an etiology related to trauma, a structure involving complex dissociative defenses, and a transference pattern related to the many alters. Such authors feel comfortable discussing DID/MPD without attending to the "Wilburian" paradigm except to attack it (e.g., Mersky, 1992; Orne & Bates, 1992; Orne & Bauer-Manley, 1991), regarding it unscientific and incompatible with the alternate hypotheses they endorse.

Acknowledging the above, I concede in advance that my attempts to discuss some of the controversial areas in regard to DID/MPD will be regarded as biased and inflammatory by those whose thinking is governed by paradigms that discount clinical data a priori in the service of an abstract scientific ideology or way of proceeding. Such apparent "respect for scientific method" all too often is recruited in the service of making an a priori dismissal of observations with which one disagrees, but cannot disprove, so that the incapacity to disprove one's opponent is bypassed and the opponent is discredited under the rubric of a scrupulous pursuit of "the truth."

As an illustration, when I met the late Nicholas Spanos, Ph.D., whose work is often cited to demonstrate that DID/MPD is iatrogenic, I asked if he had ever seen the clinical phenomena of DID/MPD that he indicated he had replicated in his social-psychological experiments (Spanos, Weekes, & Bertrand, 1985; Spanos, Weekes, Menary, &

© M.E.G.-Stiftung

Bertrand, 1986). He admitted that he had never seen a patient with this disorder, was unfamiliar with its actual manifestations, and considered these informational deficits irrelevant to his work. His paradigm was more compelling to him than the nature of the phenomenon that he purported to study.

The modern history of DID/MPD

DID/MPD, long considered rare, apocryphal, or extinct (Stengel,1943), is becoming a diagnostic commonplace in several countries. Predictably, this has given rise to acrimonious debate between those who insist the rise in DID/MPD diagnoses is faddish and/or iatrogenic, and others who maintain that due to new awareness and modern diagnostic approaches we are witnessing the long-overdue recognition of a relatively commonplace mental disorder.

Why might a diagnosis might be made with increased frequency at one point in time than another? Undeniably at certain moments in history certain diagnoses become more fashionable, and are even promoted by various social trends and pressures. There is no reason to discount skeptics' concerns that this may be occurring with DID/MPD a priori. It is my opinion and experience that some overdiagnosis is occurring, and may be egregious in isolated circumstances, but universal overdiagnosis is more myth than reality. It occurs most commonly when clinicians in a given location begin to become aware of DID/MPD but have not acquired sufficient experience with the spectrum of dissociative phenomenology. Consequently dissociative patients with symptoms falling short of DID/MPD diagnostic criteria are diagnosed with DID/MPD by clinicians making earnest mistakes about the boundaries of the condition. Also, inexperienced clinicians and/or those who accept at face value all a patient alleges may be unduly credulous of a patient's misperception and/or misidentification of his or her situation. Furthermore, many clinicians new to work with hypnosis may mistake findings that are not uncommon in the highly hypnotizable as indicators of DID/MPD, such as the demonstration of "hidden observer" phenomena described by Hilgard (1986) and ego-states as described by Watkins and Watkins (1993). However, it has been my personal experience that most neophytes and clinicians inexperienced with DID/MPD tend toward caution and underdiagnosis, fearing the censure of their peers and/or mentors.

When a clinician develops an interest in dissociative disorders and makes such diagnoses in patients that have received other diagnoses from other colleagues, it is predictable that many will remark that "Dr. X thinks everybody has MPD." Those upset with the proliferation of DID/MPD diagnoses will attack Dr. X, while those concerned with whether a patient of their own has this condition will seek out Dr. X for consultation. Probably Dr. X will be both guilty and innocent. As Dr. X grows in experience, Dr. X will become a keener observer of the more subtle signs of dissociation, and make diagnoses on the basis of findings that probably should not be called DID/MPD (but might better be classified as dissociative disorder not otherwise specified [DDNOS]), even though the patient may deserve the diagnosis by life history (see Kluft, 1985a,

1991b). In all likelihood Dr. X's wide-spectrum DID/MPD diagnoses will include both DDNOS patients who are overdiagnosed by the DID/MPD label and patients for whom the diagnosis is quite apt. Both Kluft (1985a, 1991b) and Boon and Draijer (1993) have demonstrated that on sequential reassessment most DDNOS patients with features of MPD will demonstrate episodes of overt DID/MPD. In any area in which there has been little interest in or awareness of DID/MPD, there should be a period of apparent overdiagnosis as clinicians begin to recognize the previously undiagnosed DID/MPD patients who have accumulated in the local mental health care delivery system.

Conditions will be diagnosed more frequently when increasing and/or systematic efforts are made to identify them. Prior to the 1980s the DID/MPD diagnosis was not considered on a routine basis.

"When MPD was considered a rarity, and, moreover, a rarity with dramatic and flamboyant manifestations, little attention was paid to its recognition and treatment. Given the prevailing wisdom of the era, it was reasonable to assume that sooner or later, the condition would declare itself. When MPD was thought by many to emerge as an iatrogenic artifact ... the notion of making systematic inquiry about its manifestations on a routine basis was implicitly discouraged ... Alone among illnesses and mental disorders, the clinically approved approach to MPD ... has been to conduct the diagnostic interview without making efforts to discern its presence lest it be created thereby.

Therefore, the emergence of systematic efforts to diagnose and discern the epidemiology of MPD is a relatively recent phenomenon, which could not occur before there existed (1) a recognition that the condition is sufficiently frequent to merit such inquiries; (2) an awareness that the condition occurs naturalistically apart from interventions that might be seen to induce it; and (3) effective treatments so that it is useful to discern its presence or absence" (Kluft, 1991b, pp. 606-607).

Several factors make it more likely that DID/MPD will be diagnosed and recognized by modern clinicians (Kluft, 1987a). Foremost has been feminism, which sensitized society to the widespread exploitation of women and children. It helped to create an atmosphere in which complaints of abuse could be heard more sympathetically, and in which posttraumatic conditions became associated with women's issues. Also, the tragic aftermath of the Viet Nam war, which forced the mental health professions to look carefully at posttraumatic stress disorder (PTSD), a condition with many dissociative components, brought about fruitful cooperation and collaboration between the students of PTSD and DID/MPD. The rise of biological psychiatry teased apart many overlapping syndromes - out of the study of those who did not respond to treatment with available measures many proved to be both traumatized and highly dissociative. DSM-III (American Psychiatric Association, 1980) distinguished the dissociative disorders as a free-standing group, emphasizing their legitimacy as mental disorders. Increased interest in hypnosis led to a growing number of clinicians who became familiar with hypnotic and dissociative phenomena. When they encountered these phenomena in patients, they were prepared to appreciate both the nature and implications of finding a dissociative psychopathology.

The efforts of pioneers in the DID/MPD field led to the availability of workshops

© M.E.G.-Stiftung

that trained an increasing number of clinicians to diagnose and treat this condition. By 1980, the literature began to explode with pioneering publications on DID/MPD (Greaves, 1980; Bliss, 1980; Coons,1980; Braun, 1980; Marmer, 1980). Greaves (1993) has profiled the modern history of DID/MPD. Growing rapidly, the field discovered the natural history of DID/MPD (Kluft, 1985), enhanced its diagnostic sophistication (Coons, 1984; Kluft, 1985b, 1987a, 1987b), and developed specialized approaches to diagnosis including relatively novel interviewing approaches (Putnam, 1989), a specialized mental status examination (Loewenstein, 1991), screening instruments (Bernstein & Putnam, 1986), and structured diagnostic instruments (Ross, 1989; Steinberg, 1993a, 1993b). Given this wealth of information, it would be most remarkable if an increase in the number of DID/MPD patients being diagnosed had not occurred. The objection that this may be related to unduly lax diagnostic criteria is unlikely. Most experts conclude that DSM-IV criteria exclude no more than five percent of cases diagnosed by DSM-III-R criteria.

It appears most likely that the modern increase in the diagnosis of DID/MPD patients, notwithstanding some overdiagnosis, is the natural outcome of increased awareness and diagnostic sophistication.

The etiology of DID/MPD

Arguments surrounding the etiology of DID/MPD have been one of the most characteristic and consistent of the modern controversies. A more detailed discussion of etiology is available elsewhere (Kluft, 1995).

Is DID/MPD a mental disorder or a syndrome?

Controversies exist as to whether DID/MPD is a freestanding mental disorder or a syndrome that develops in the context of other mental illnesses. DID/MPD may coexist with a wide range of other symptomatology, which may, in a given case, represent epiphenomena of the DID/MPD, independent comorbid conditions, or both. It often is not possible to determine the relationship of the dissociative disorder to the other phenomena without longitudinal observation and study and careful attention to the response of those phenomena to various treatment interventions. If one assumes a priori that a particular condition is primary, and that fluctuations in DID/MPD phenomenology that parallel the fluctuations of the condition assumed to be primary indicate that DID/MPD is a symptom of the other condition, it will be easy to make a case for DID/MPD's being a syndrome alone. However, if one appreciates that it is very normal for the vicissitudes of one condition to impact on another, even if both are separate conditions, such inferences must be discarded or qualified. Kluft (unpublished data linked with 1985a) found that although the responses to treatment of affective disorders in patients with MPD/DID phenomena did lead to changes in the DID/MPD phenomena, and might be associated with a transient waxing and waning of dissociative symptoms, there were no instances in which the control of the affective disorder led to the complete cessation of

DID/MPD manifestations.

MPD/DID can occur in patients with many forms of Axis 2 psychopathology (Fink, 1991), some of which are associated with brief psychotic episodes. Also, highly hypnotizable individuals are vulnerable to the development of hysterical psychoses. This, in addition to the coexistence of MPD/DID with affective disorders that may involve psychotic features, and with schizoaffective disorders in uncommon situations, leads to the possibility that DID/MPD may be encountered in patients with neurotic, borderline, and psychotic levels of ego strength and defenses. Again, in this context only the a priori assumption that one psychopathology is primary will lead to the second disorder's being considered a syndrome by comparison.

In order to demonstrate that a particular set of findings constitute a free-standing disorder, one must demonstrate that they have characteristic symptoms and a natural history over time, and that any postulated hypotheses hold on follow-up, rather than only for a brief period of observation (Woodruff, Goodwin, & Guze, 1974). Kluft (1985a) followed over 210 MPD patients in order to determine the natural history of DID/MPD. He characterized patterns of its manifestations (1985a) and defined a typology of presentations (1991a) that was unrelated to the waxing and waning of comorbid disorders. He also noted that in some patients with both affective disorders and dissociative disorders the dissociative disorders were refractory and could not be controlled until the affective disorders had been treated successfully (1988a). He found that DID/MPD rarely responded to treatment that did not address the condition specifically (1985a, 1993a). No untreated patients lost their DID/MPD. Only 2-3% of the patients in therapies that addressed their other problem areas but did not deal directly with the DID/MPD were relieved of their dissociative symptoms in a definitive manner (1993a).

The above observations are most consistent with the hypothesis that DID/MPD is a disorder rather than a syndrome, but they do not rule out the possibility that at times the manifestations of the disorder can occur as a syndrome associated with another disorder.

Is DID/MPD an naturalistic mental disorder, or is it an iatrogenic condition?

It is not uncommon for clinicians (Merskey, 1992), clinical investigators (Kampman, 1976), and scientific investigators (Spanos, Weekes, & Bertrand, 1985; Spanos, Weekes, Menary, & Bertrand, 1986) to state that DID/MPD is an iatrogenic artifact, limited in distribution to areas where clinicians evoke such artifacts on a fairly regular basis. Fahy (1988) described DID/MPD as a North American culture-bound condition. Hypnosis is alleged to play a major role in its genesis, along with the pathological interest of the clinician, who is portrayed as generating cues and expectations that ultimately influence the patient to manifest DID/MPD (Kluft, 1995a). Unfortunately, space precludes a discussion of how many factors must be accounted for to establish iatrogenesis, a topic discussed elsewhere (Kluft, 1995a). Here only one point will be made: to allege that because DID/MPD manifestations follow an intervention they were caused by that intervention does not prove causality, but may illustrate the post hoc, ergo

© M.E.G.-Stiftung

propter hoc fallacy. To discover a lesion after an x-ray is taken does not prove that the x-ray caused it. The following discussion is drawn from Kluft (1995a).

The allegation that DID/MPD has developed after a mental health professional has made inquiry about its manifestations or about whether the patient has endured abuse is easy to make, but difficult to sustain. First, it must be demonstrated (not merely alleged) that neither DID/MPD nor a condition known to be associated with more covert manifestations of DID/MPD (such as DDNOS) was present prior to the interventions. Second, one must prove (rather than insist or opine) that DID/MPD indeed can be created by the interventions that are alleged to have created it. Third, it must be shown that the interventions that are alleged to have created the DID/MPD have indeed occurred, have been registered by the patient, and are sufficiently potent to have been capable of having created the alleged effect. Fourth, it must be established that efforts to prevent such an outcome have not been made, or have been insufficient or unsuccessful. Fifth, the absence of alternative credible explanations for the presence of DID/MPD phenomena must be demonstrated. Also, sixth, even if it is agreed that the conditions necessary to produce iatrogenic DID/MPD are present, it must be demonstrated that they and not some other factors were the definite causative agent rather than a minor contributing factor.

Because DID/MPD is usually covert and DID/MPD patients are usually secretive, it is very difficult to prove that the condition was not present before becoming manifest. What makes a condition manifest is not necessarily what has caused it. For example, it is not unusual for an unsuspected bipolar disorder to become clinically manifest when a psychiatrist prescribes an antidepressant for what was thought to have been major depression alone, but the psychiatrist is not thought to have created de novo disease thereby. Likewise, it is not credible to argue that beginning psychotherapy or administering a comprehensive diagnostic evaluation in which questions about dissociative disorders have been asked has created DID/MPD without being vulnerable to the counterargument that one has indulged in a post hoc, ergo propter hoc type of fallacious reasoning.

To maintain a condition has been caused by a particular intervention, the possibility of such an outcome must have been established. The literature contains many allegations of the iatrogenesis of the full and sustained picture of DID/MPD, but no convincing demonstrations of this phenomenon. Elements of earlier iatrogenesis experiments were repeated by Kluft (1982), who found that the results were not consistent with clinical DID/MPD. Instead, his efforts lead to transient situation-dependent and often uncooperative permeable ego state manifestations (as in Leavitt, 1947), enactments of past life suggestions (as in Kampman, 1976), and dissociative phenomena such as automatic writing (as in Harriman, 1942). Spanos, unfamiliar with DID/MPD, created transient amnestic and role-playing phenomena, not the clinical condition itself (Spanos, Weekes, & Bertrand, 1985; Spanos, Weekes, Menary, & Bertrand, 1986). Elsewhere Kluft (1995a) observed that Spanos had never addressed the pars pro toto fallacy built into his expectations and criteria for success. If mere enactment of certain aspects of a

role establishes the legitimacy of a condition, then certainly it is fair to reason that the subject of a stage hypnotist who can be induced to cluck like a chicken should be cooked for dinner! Estabrooks, one of the great hypnotists involved in efforts to create DID/MPD analogs for use in military and espionage settings, reported that it took months of work with cooperative subjects to create reliable ego state phenomena for simple courier work (Ross, 1994). Therefore, it is difficult to accept at face value the argument that one or more questions or subtle hints in a diagnostic or therapeutic interview will bring about full-fledged DID/MPD with facility. In the absence of a single credible demonstration of the iatrogenesis of DID/MPD, any allegation of the iatrogenesis of DID/MPD must be regarded with great caution and misgiving.

The failure of iatrogenesis experiments to create this disorder makes it difficult to demonstrate that interventions alleged to have created an iatrogenic version of the disorder are potent enough to do so. Most clinicians are quite alert to the problems associated with leading questions or using models of questioning that resemble police interrogations (see Brown, 1995). Exceptions include therapists who work with substance abusers. Many substance abusers deny their illness. Those who apply the vigorous confrontations and interventions necessary to reach the alcoholic or drug addict to other groups may overstep all reasonable limits that clinical experience and memory research would dictate as prudent, and virtually force acknowledgement of phenomena and experiences down the throats of the pliable, suggestive, and desperate.

No effort to argue for iatrogenesis has shown that no alternative explanation is possible. One of Janet's few documented possible clinical errors relates to his claims about the iatrogenesis of DID/MPD. He believed that hypnosis had created DID/MPD, but he made this allegation about a patient who had shown florid dissociative phenomena for years before the hypnotic interventions that were alleged to have created her condition (Kluft, 1982; Braun, 1984). Finally, no study or clinical vignette put forth as a demonstration of iatrogenesis has shown that the interventions alleged to have brought this about were the sole or major causative agent as opposed to being one of many contributing factors.

Because it often is stated that hypnosis can create DID/MPD and that "experts" using hypnosis can "make" patients DID/MPD quite readily, it is important to appreciate the work of Ross and Norton (1989). Comparing DID/MPD patients who had and had not been hypnotized, they found no difference in most phenomena, diminishing the likelihood that the mere use of hypnosis could create major impacts on dissociative phenomenology, even resulting in de novo DID/MPD. Ross, Norton, and Fraser (1989) also compared the phenomenology of DID/MPD patients diagnosed by "MPD specialists" and those with no particular interest in dissociative disorders. No appreciable differences were discovered. If one wishes to argue that either hypnosis or "enthusiasm" is to be alleged to be a factor in causing iatrogenic DID/MPD, one must contend with the fact that neither of these factors appears to have a significant impact on the DID/MPD phenomena elicited. This may have occurred in individual cases, but cannot

© M.E.G.-Stiftung

be assumed to be a prevalent outcome. It seems most parsimonious to regard the iatrogenesis hypothesis as unproven, and its frequent endorsement as a reflection of the types of bias discussed earlier in this paper.

The iatrogenic worsening of DID/MPD

The iatrogenic creation of DID/MPD is unproven speculation, but the iatrogenic worsening of DID/MPD is a very serious clinical problem of unknown prevalence that cries out for attention. The furor that has surrounded the issue of de novo iatrogenesis has diverted attention from this crucial issue. In 1982 I reported a patient whose complexity was increased by the inept use of hypnosis by a practitioner untrained in its use. The David Caul Memorial Symposium (1989), with contributions from Braun, Coons, Fine, Greaves, Kluft, and Torem (all 1989) included many examples of therapeutic misadventures. At times the dissociative patient protects him or herself from the impact of a maladroit or poorly-paced treatment by dissociating, and may, defensively, form additional personalities.

The practitioner who refuses to address the DID/MPD may create pressures that impel such patients either to dissociate further to sequester that for which they will receive no help, or to create even more dramatic "proofs" that the condition is, in fact, present. In the former case, the alters will be kept far from the therapy and the therapist, who will see no trace of what is occurring, and feel confirmed in the belief that a policy of non-reinforcement is reducing the disorder. In the latter, the therapist will feel confirmed in his or her opinion that the patient is a mythomaniacal and narcissistic character disorder patient, probably of the borderline variety, and that such turmoil is a protest against the withholding of inappropriate gratifications and interventions. Either the patient will subside, or leave treatment.

What of the therapist who does not deny the disorder, but who either is fascinated with it or mistakes scoptophilic exploration of the alter system for treatment? Such a therapist conveys that he or she is more interested in the panoply of psychopathology than the patient as a person, or the patient's recovery. In order to please the therapist, in response to suggestions (implicit and explicit, direct and indirect), and in the erroneous impression that they are proceeding well in therapy, patients may overlabel phenomena as additional alters, or even create some. What of the therapist who makes a bee-line for the traumatic material without doing the necessary preparatory psychotherapy? The patients of such therapists may need to form new alters to handle the overwhelming pressure of such premature uncovering, to provide alters and memories as material for the therapist, and to create alters that appear to cope well in order to help them escape the pressure of the therapy.

It is crucial to appreciate the triphasic nature of the treatment of the traumatized (Herman, 1992) and its implications for the treatment of DID/MPD patients (Fine, 1991; Kluft, 1988a, 1989b, 1993a, 1993b). It is necessary to create a situation of safety in the therapy before going into the remembrance of trauma and the mourning of its

impact, which in turn must occur before successful intrapersonal and interpersonal reconnection. Therapists who do not respect these observations and the principles of pacing that follow from them (Fine, 1991, 1993; Kluft, 1991a, 1993a, 1993b, 1993c) are likely to retraumatize their patients and create pressures to which they may respond with further dissociative elaborations.

Not only should the treatment be carefully paced to avoid such untoward events, but the therapist should abstain from imposing his or her beliefs about the structure of alter systems and from going on vigorous "trauma hunts." Both have high potential for complications, with expansion of the alter system and the generation of pseudomemories which may be sufficiently formidable to verge upon pseudologia fantastica. Two egregious examples of personality types that seem to be reported more in areas in which large numbers of therapists believe in their ubiquity are the inner self-helper (ISH), first described by Allison (1974), and the "central core" personality, described by a number of practitioners in Ohio and Canada. Luckily these two types of alters, even if artifactual, are often constructive and useful. However, in areas where religious beliefs endorsing the actual presence of the devil and his minions on earth are prevalent, patients in treatment with therapists holding such beliefs can be done a major disservice by being encouraged to believe they have, and thereby generating, demonic alters.

Likewise, although it is useful to take histories, it is important to respect amnestic barriers early in treatment unless there are firm clinical indications to the contrary. Taking the histories of a number of alters certainly may uncover more traumata than the patient can manage. When it seems possible this could occur, usually it becomes important to curtail exploration except in the most general terms until the treatment has addressed what has already emerged. The resolution of one layer of pathology is often sufficient to prompt the emergence of the next, and is less associated with overwhelming the patient or generating pressures toward pseudomemory formation, and with it, the potential of instigating additional alters to contain these "traumata" that never occurred, but conceivably might be believed in forever.

Some difficulties are associated with the misuse of basically constructive techniques. Here two very common misadventures will be discussed: the overuse of journaling and excessive preoccupation with mapping the personality system. Journaling was suggested by the early pioneers because (1) many alters identified themselves for the first time in writing; (2) for many alters "telling" was prohibited, but writing was not understood to be; (3) journaling often was a valuable outlet between sessions; and (4) by contributing to and reading a joint journal, alters could begin to become aware of one another and breach dissociative boundaries. However, if a patient journals excessively, not only will he or she generate too much for the therapist to read, but there is danger that autobiography and intercommunication can degenerate to a solipsistic fantasy game in which imagination replaces reality. The author advises against patients' journaling more than 20-30 minutes per day. An occasional patient will journal for hours, and become lost in the vicissitudes of his or her internal worlds. Alters can be

created to fill in the roles necessary in these inner worlds, a complication described by Kluft (1988b). Many therapists and patients appear unaware of this potential hazard.

Excessive mapping of the alter system can also miscarry. When correctly done (e.g., Fine, 1991, 1993), mapping is a useful exercise. It is done early in therapy, and perhaps occasionally thereafter to assess intrapsychic changes and alterations in amnestic barriers and alter systems. However, I have seen countless instances in which patients have spent hours of time daily for weeks and months in such pursuits. Several therapists have come to me in consultation and shown me maps including upward of 10,000 alters and asked me what to do. They usually are not happy when I explore the possibility that the map is the record of imaginative play perverted into a fantasy game in which both patient and therapist have left reality far behind, and created a new shared "reality" in which the therapy takes on the features of a game of "Dungeons and Dragons" run riot.

A problem of substance, factitious DID/MPD

The field's preoccupation with the iatrogenesis issue has detracted attention from factitious DID/MPD and the factitious elaboration of legitimate dissociative disorders. These are problems of genuine concern, but of uncertain incidence and prevalence. A series of such patients has been reported by Coons (1994a). Elsewhere (Kluft, in press) I have outlined some of the many dynamics that can motivate the use of a false or factitious history and alter system as a defense. Suffice it to say that for many individuals, the features and alleged experiences of DID/MPD patients are preferable to their own self-perceived baseline realities. The study of factitious DID/MPD and the factitious elaboration of legitimate DID/MPD remains quite preliminary and incomplete.

A painful clinical reality: naturalistic, iatrogenic, and factitious features can be found in the same patient

It is always tempting to attempt to smash an adversary with whose point of view one disagrees. If life were played by the same rules as a formal debate, this might be a functional stance. Unfortunately, assuming one's adversary is completely out of touch with reality is rarely either accurate or helpful. It is useful to study one's adversary's point of view, and to try to discern how it could be inferred in good faith from phenomena that are actually present. When I pursued this approach in my 1987(c) study of "The Simulation and Dissimulation of Multiple Personality Disorder" I discovered that naturalistic MPD phenomena superficially mimic behaviors that forensic experts associate with malingering. Consequently, it is only natural that such authorities, working within their customary paradigms, would be very likely to dismiss most DID/MPD patients as malingerers.

When we examine the iatrogenesis argument in a similar spirit, it is enlightening to observe that many characteristic DID/MPD phenomena are very much like those one would expect to encounter in an iatrogenic or factitious situations. This circumstance, combined with the factors described above, would be sufficient to convince many col-

leagues that any and all DID/MPD manifestations can be attributed to iatrogenic or factitious etiologies. Space does not allow an extensive exploration of this subject, but a few observations on the deconstruction of some of these patients' manifestations may be instructive.

DID/MPD patients vary widely with respect to their abilities to control switching and the creation of new alters. Some DID/MPD patients have alters that more or less determine which alters will assume executive control of the body. In some patients particular alters have been assigned the role of creating new alters. Regardless of the degree of volitional control in a given patient, it is clear that the process of alter construction draws heavily upon external influences, both with regard to the instigation of new dividedness and the form taken by the new dividedness. Consequently, we should not be surprised to find that DID/MPD patients can form new alters rapidly in response to their external circumstances. Their readiness to do so could be construed as evidence for iatrogenesis by those who do not appreciate the adaptational value of such a capacity.

As Spiegel (1986, 1991) has observed, dissociation involves the segregation of certain sets of information from others in a relatively rule-bound manner, and dissociation is an ad hoc and on-line defensive process rather than a retrospective defensive operation with regard to trauma such as repression. These patients developed alters in response to intercurrent stressors in childhood, and may retain this capacity as adults, forming alters to adapt to evolving situations. It is not unusual to find that a child has formed an alter to cope with a traumatic experience and/or another to manifest behavior that will propitiate an abuser. Nor is it unusual to find that a hospitalized adult DID/MPD patient has formed a new alter to cope with the stress of the hospital stay, and/or to manifest the type of behavior that will allow him or her to appear ready for discharge.

Imagine such behavior from the perspective of a person who enters the situation strongly inclined to perceive the condition as iatrogenic. Such a person might be likely, even predisposed, to conclude that the patient in question rapidly learned that alter formation was encouraged and prized by the psychiatric staff of the hospital, and is complying with the cues and demand characteristics of the situation.

DID/MPD patients, along with most who have been abused as children, become skilled at reading others in order to figure out how to behave in order to anticipate and avoid difficulties. They become capable of manipulating themselves and others to achieve at least an illusion of safety or control of their circumstances. In this they inevitably overlap with that group of patients that feign or produce symptoms in order to achieve and maintain the patient role, those who suffer the factitious disorders. It is not uncommon for DID/MPD patients to become demoralized about their prospects for recovery, and to dedicate themselves to finding and holding on to some facsimile of safety and connectedness in their often difficult and complex lives. Consequently, it should not be surprising that an unknown but significant percentage of DID/MPD patients spend a great deal of effort in achieving and maintaining the patient role, including the development of attention-demanding symptoms and behaviors designed to create, protect, or enhance their patient roles. They have been encouraged in this by the increasing inroads of models of health care delivery systems that attempt to minimize the utilization of services by patients, creating incessant fears of abandonment and the loss of their relationships with their therapists. We should expect to see an increase in factitious components to mental illnesses as attempts are made to deprive very needy and unstable patients of the level of therapy that serves to contain and support them. It should not be surprising that the motivation to preserve the patient role, for both good reasons and bad, will generate some DID/MPD behaviors that make both specialists and skeptics shake their heads in astonishment and amazement.

It is useful to appreciate that the phenomena of the DID/MPD patient, like the patient suffering from any other type of mental disorder, do not develop in a vacuum. Imbricated within findings that have been characteristic of this condition from its first descriptions in the clinical literature will be the flotsam and jetsam of contemporary culture and the residues of experiences and interactions with the mental health care professions. Within the alter system of one of my patients were alters based upon Jacqueline Kennedy Onassis, Madonna, Anna Freud, and a former therapist. A young boy I assessed sixteen years ago had alters based on his parents and characters from the "Flintstone" and "Jetson" cartoon families, while one I interviewed two years ago had several alters based on the more contemporary "Mutant Ninja Turtles," and of two seen during the preparation of this manuscript, one had an alter based on the "Power Rangers," and the other had an alter based on the flamboyant entertainer, Madonna.

Other controversies in brief

Are the traumata alleged by DID/MPD patients actual recollections or fantastic pseudomemories?

However polarized and politicized this concern has become, it is imperative to appreciate that it is usually unresolvable in any given case. Like most pursuits of ultimate truth, it is doomed to frustration except when conducted by those who either by dint of ignorance and/or arrogance and/or over-zealous application of a paradigm or belief outside its area of validity presume to have more wisdom than their colleagues. Man's memory is imperfect and vulnerable to decay and distortion by post-event information and all varieties of contaminants, including the retrieval cues under the aegis of which the search of memory is conducted. Confabulations and pseudomemories are not new discoveries, they are classic findings. Human memory, however vulnerable and potentially flawed, is serviceable enough to address most of the daily and long-term needs of the species. Recently Loftus (1993) reviewed the subject of repressed memory in a less than dispassionate manner, but succeeded in raising many important concerns about the accuracy of recovered memories. She raised the issue of whether the long-

delayed recovery of memories from childhood could be given credence. It is commonplace to assert that true traumata are not forgotten - they are all too present. However, it long has been appreciated that combat soldiers are often amnestic for some of what they have been through (e.g., Sargent & Slater, 1941), and Kooper, Classen, and Spiegel (1994) have demonstrated that it is not uncommon for memory to be affected by trauma due to natural disasters in non-patient populations. Briere and Conte (1994) and Feldman-Summers and Pope (1994) have shown that it is not uncommon for people to have periods during which they did not remember childhood traumata that they generally recall. Herman and Schatzow (1987) demonstrated that of women alleging incest, including those who only recalled the incest after it had long been repressed or dissociated, 74% could get good confirmatory evidence, and 9% could find suggestive but less persuasive evidence. Williams (1992, 1994) has shown that 38% of women interviewed seventeen years after documented childhood trauma did not recall the documented trauma at the time of the study. These findings suggest that the allegations made by DID/MPD patients both on the basis of consciously available memories and recovered memories should not be dismissed out of hand.

To address specifically the allegations of traumata made by DID/MPD patients, there are a surprising number of relevant studies even excluding documentation in specific individual cases. Bliss (1984) investigated some allegations by DID/MPD patients and could get confirmation for aspects of the accounts of 8 of 9 subjects. Coons and Milstein (1986) confirmed aspects of the trauma alleged by 85% of 20 adult subjects. Hornstein and Putnam (1992) noted that the abuse of 95% of their 66 child and adolescent dissociative disorder patients had been documented, a finding replicated by Coons (1994b), who also got confirmation in 95% of a series of 22 dissociative children and adolescents.

Most recently, Kluft (1995b) reviewed the charts of 34 DID/MPD patients without doing any special investigations and, using fairly stringent criteria for corroboration (confessions, eye-witness accounts, and legal/police documents) found confirmation of at least one abuse alleged by 19 or 56% of the patients in his series. More striking, although 10of the 19, or 56% could confirm allegations that they had always held in recall, 13 of the 19, or 68%, obtained documentation of events that were recollected only in the course of therapy, mostly with the use of hypnotic facilitation. He also documented the inaccuracy of memories in three (9%) of his patients.

Clinical circumstances often make it impractical, impossible, or contraindicated to "play detective" or to interview ancillary sources. I have had the experience of following many DID/MPD patients for a decade or more. This has allowed me to observe that often families that deny all allegations of a DID/MPD patient change their story once the significant alleged perpetrators have passed away or become separated from the family. In one instance, the sister of a woman who alleged massive intrafamilial abuse had maintained for 11 years that the patient was lying about what had occurred in the family. However, upon the death of their parents, the sister began to discuss their past

© M.E.G.-Stiftung

openly, and admitted that she, too, had suffered similar mistreatment.

Yet clinical experience also allows us to see that some allegations are simply dead wrong, and are based on either lies, fantasies, the doings of the alter system, pseudo-memories, or other influences. Recently the author was told by a hospitalized adolescent that she had been raped on a pass. She was sent to a forensic rape trauma unit which documented findings already noted at a gynecological appointment earlier the same week. It was possible to reconstruct the events of the pass and determine that she had never been alone with the person whom she alleged had raped her.

Polarized stances of skepticism toward recovered memories on the one hand and of believing implicitly whatever patients recount on the other both fly in the face of strong scientific and clinical evidence, are without credibility, and are capable of generating more misadventure and mischief than any caring professional would wish to visit upon his or her patient (and more than any circumspect professional would wish to visit upon him- or herself). To pretend otherwise demands that we place our beliefs, theories, and politics above data. Freud admired his teacher Charcot's axiom, "Theory is good, but it does not prevent things from existing" (Freud, 1893, p. 13). It remains a most useful caution to those who verge upon becoming "true believers." Elsewhere (Kluft, in press a) I have addressed the clinical implications of working within an atmosphere of "informed uncertainty" that acknowledges both the limitations of our capacity to determine the truth and the fact that recovery can occur without its being determined.

Does active treatment of DID/MPD phenomena reinforce or resolve DID/MPD?

The development of systematic approaches to the treatment of DID/MPD (e.g., Braun, 1986; Kluft, 1991; Putnam, 1989; Ross, 1989) has not been greeted with unabashed enthusiasm. Instead, voices have been raised to suggest that such approaches reify and reinforce the disorder, complicate its management, and prolong the patient's morbidity. Fortunately, there is data to suggest a resolution to this debate.

In a series of articles, Kluft (1982, 1984, 1985a, 1986, 1993a) traced aspects of his longitudinal study of over 210 DID/MPD patients. He compared both treated and untreated patients. Among the treated groups he was able to follow patients treated by therapists who disagreed with the diagnosis, who accepted the diagnosis but did not treat it directly, and those who treated it specifically and directly. The findings were unequivocal. Of the patients treated by those who disagreed with the diagnosis and would not treat its manifestations actively, all retained active DID/MPD on reevaluation. Of those treated by therapists who did not dispute the DID/MPD diagnosis but who did not address it specifically and relied on what they considered "good therapy" to ultimately resolve the dissociative disorder, only approximately 3% did not have the condition on follow-up. These results are inconsistent with the frequently-voiced advice that the condition ceases if not reinforced.

In contrast, Coons (1986) followed 20 such patients in therapy with 20 therapists for

an average of 39 months. 19 of the 20 therapists were working with their first DID/MPD patient, and many were trainees. Two-thirds of the patients were considerably improved, and 25% had integrated. Kluft, working with data drawn from the patients from his own practice and a few from the practice of the late Cornelia B. Wilbur, M.D., found that of patients who were in treatment at least three months, 90% remained in treatment and 90% of them integrated. Neither the Coons study, based on the work of trainees and therapists working with their first DID/MPD patient, nor the Kluft study, based on the work of experts, can serve as the basis of many generalizations, because neither represents the work of the average therapist and the average patient. Also, some data indicates that Kluft was studying a much healthier group than Coons (Kluft, 1994a). However, these studies demonstrate that supervised trainees doing specific active DID/MPD with their first cases do better than experienced therapists who do not address the condition directly. This is a powerful argument in favor of active direct treatment of DID/MPD.

That having been said, the active and direct treatment that proves effective always builds in a number of safeguards to discourage the reification and further elaboration of the dissociative psychopathology (Kluft, 1993a, 1993b). Most of the major figures in the treatment of DID/MPD have always been aware of and sensitive to the risks of inadvertent iatrogenic complications and regressive dependency, and conducted their clinical work with as much scrupulosity as the give and take of clinical work allows.

Does the use of hypnosis facilitate or compromise the treatment of DID/MPD?

The very existence of this venerable debate is based upon a host of misconceptions, most of which are relatively recondite to all but a small group of students of hypnosis. Here I will only note a few relevant issues. The first is that it often is possible to treat DID/MPD patients without ever inducing hypnosis, but it is completely impossible to treat them without hypnosis. This is not clever wordplay - it is an acknowledgement of clinical and theoretical reality. Following the observations of Spiegel and Spiegel (1978), hypnosis comes in three forms: spontaneous trance, autohypnosis, and heterohypnosis (following a ritual of induction performed by another person). Breuer and Freud noticed spontaneous trance and autohypnosis in their DID/MPD patient Anna O. (Breuer & Freud, 1893-5). Bliss (1986) has attributed this disorder to the unwitting abuse of autohypnosis. Given that the patient will experience naturalistic trance and autohypnosis, the decision to abjure the use of heterohypnosis deprives the clinician of the opportunity to help the patient restructure his or her autohypnotic proclivities and patterns, and leaves the patient's psychopathology with an often insurmountable "home field advantage" (Kluft, 1992a, 1992b). While some patients' dissociative defenses and barriers can be treated without the use of formal hypnosis, some patients are encountered for which this is not possible for prohibitively prolonged periods of time (if at all), and their treatments may founder (Kluft, 1987d).

© M.E.G.-Stiftung

The real issue here is not whether to use hypnosis, which is inevitably a part of these patients' treatments, but rather which uses of hypnosis are likely to be helpful and which are potentially detrimental. This is a point on which authorities who are usually at odds often agree. There is considerable consensus that the use of hypnosis for integrative and supportive purposes is appropriate. There is dispute over whether the use of hypnosis for the exploration of the alter system and for the retrieval of historical materials is appropriate. While there remains considerable room for debate, it is clear that excellent clinical results have been achieved by psychotherapists who employ hypnosis in this manner. It is also clear that the cautions of those who fear iatrogenic increases in the complexity of the alter system and the generation of confabulations and pseudomemories are not without substance. At this point in history, it appears that the decision as to whether hypnosis should be employed for these purposes in a given clinical situation is a matter for experience and clinical judgment to decide. My own experience has demonstrated that since most clinical stalemates are related to the presence and activities of as yet undiscovered alters, and many troubling symptoms are as well, there is often substantial justification for such explorations (1988c). For example, a DID/MPD patient in treatment with me for only three weeks began to have apparent grand mal seizures. I induced hypnosis and asked to speak to the alters behind the seizures, and soon had them in conversation. The seizures were both defenses against the revelation of certain traumatic events and representations of them. I told these alters that I was in no rush to unearth upsetting material before the overall patient was prepared to face them, and saw no reason to force them to speak before they were ready to do so. They agreed to stop creating the seizures and to discuss their concerns in treatment when they were ready.

My experience has taught me that unless there is reason to suspect that the patient will be involved in legal proceedings, which might contraindicate any use of heterohypnosis, I can consider the judicious use of hypnosis to revisit material that has already been offered for therapeutic purposes. However, I tend to be very circumspect and cautious when the issue is the accessing of memories de novo. I generally try to avoid such explorations unless there are specific clinical indications to do so. If the patient and I elect to proceed, it is only after we have explored the pluses and minuses of such a decision and the patient has come to a position of genuine informed consent. Usually I have found alternative methods to approach the material in question. A frequent approach is to discuss the situation with an alter that is protesting the revelation, and press for an ample exploration of the rationale for withholding. Usually a process evolves in which the material is revealed by a concerned alter without hypnosis. In my experience, one fairly frequent indication for such hypnotic explorations is therapeutic stalemate in an uncomfortable but otherwise cooperative and accessible patient who is without forensic entanglements, who has given informed consent, and who has demonstrated the capacity to contain him or herself rather than to immediately push to take action on what has emerged in the therapy. The latter is a prerequisite, because the patient who

will move to act on materials before they have been processed in therapy is too labile to work with in this manner. Such a patient may damage his or her own life and the life of others by making unwise accusations and confrontations based on materials of uncertain veracity, and of unestablished psychodynamic significance. A verbatim transcript of many useful hypnotic techniques is available (Kluft, 1994b).

Are specialized dissociative disorders units a therapeutic advance or hotbeds of contamination and contagion?

McHugh (1993) has argued against such units. He drew his reasoning from the experience of Babinski in addressing the iatrogenic hystero-epilepsies on Charcot's ward of the Salpetriere. Since the condition in question (hystero-epilepsy) was iatrogenic, clusters of patients vulnerable to such influences would in all likelihood begin to manifest the symptoms that were of interest to the doctors who provide such suggestions and implicit inducements. Assuming afflicted patients would reinforce one another's psychopathology, it stood to reason that one should disperse rather than concentrate such patients, and take pains not to demonstrate potentially reinforcing attention to the symptomatology. Indeed, this is consistent with the author's experience with gross symptom contagion.

Unfortunately for McHugh's argument, the evidence that DID/MPD is completely iatrogenic is nil. Unfortunately for those who argue for such units, that the condition is not iatrogenic does not demonstrate that its complications and elaborations cannot be iatrogenic, despite the vastly overstated nature of McHugh's concerns.

In favor of such units is the often dismal track record of general units in working with such patients, and the problems that may surround the treatment of DID/MPD patients in general settings (Kluft, 1991c). In years of consultation to hospital milieus, it has been my experience that unless a general psychiatric unit is willing to prioritize achieving excellence in working with dissociative disorder patients, and accord such expertise the same respect that is given to expertise in working with the traditional patient populations, it is unlikely that the DID/MPD patient can be treated with equal effectiveness in a non-specialized setting.

The specialized unit can be a wonderful resource, but it can be vulnerable to some of the problems that concerned McHugh. Not all specialized programs are equal in quality, and often their differences in quality are related to the adroitness with which the staff contains the potential for chaos and contamination when such patients are brought together.

Granted the competence of the staff of a specialized unit in addressing the concerns above, specialized units can do a much more reliable job containing DID/MPD patients' distress and providing support for specialized interventions than units unfamiliar with novel and useful procedures and the myriad nuances of DID/MPD patients' situations (Kluft, 1992c). In the author's six years of experience as the chief of a specialized dissociative disorders program, he has found that this environment provides an

© M.E.G.-Stiftung

unparalleled opportunity to work rapidly and effectively with DID/MPD patients. He has been able to achieve results more quickly and efficiently than he had been able to in general hospital psychiatric units or general adult units in psychiatric hospital settings. Patients treated on his unit who had had prior experience in non-specialized settings report that they are better able to focus on their therapeutic work in a setting in which their concerns were not unique, special, or unfamiliar to the staff.

In considering the usefulness of the specialized program, it is important to bear in mind that most of the treatment of a DID/MPD patient will take place in the outpatient setting. Therefore, with rare exceptions, the major goal of a period of hospital treatment is to build a better outpatient. The enhancement of stability, mastery, and coping is a significant focus, even in hospital stays designed to support intensive exploratory and/or abreactive work, or to deal with problematic alters (Kluft, 1991c). In our program we try to monitor every treatment to assure that uncovering and potentially destabilizing interventions are balanced with stabilization efforts, and that reasonable pacing is observed.

Concluding comments

These brief remarks offer a preliminary and inevitably superficial treatment of several controversies surrounding DID/MPD, all of which deserve more extensive treatments, and do not consider many others at all due to considerations of space. At this point in time, it is unlikely that any arguments, however potent, will resolve the polarized debates and frequently impassioned controversies that continue to swirl about Dissociative Identity Disorder (Multiple Personality Disorder). Many authorities currently writing on both sides of these disputes often appear too caught up in the fervor of the situation to achieve dispassion and objectivity.

To draw a biblical analogy, perhaps contemporary major contributors to the field and their critics can be understood as a generation that, like that of Moses, has matured under the oppression of circumstances and events that preclude their ever reaching the promised land of a clearer understanding. Perhaps it will require the rising of a new generation, untainted by those circumstances and the controversies that arose from them, to achieve the completion of this journey.

References

Allison, R.B. (1974). A new treatment approach for multiple personalities. American Journal of Clinical Hypnosis, 17, 15-32.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders - 3rd Ed. Washington, DC: Author.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders - 3rd Ed. - Revised. Washington, DC: Author.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders - 4th Ed. Washington, DC: Author.

Baron, J., Beattie, J., & Hershey, J.D. (1988). Heuristics and biases in diagnostic reasoning: Congruence, information, and certainty. Organizational Behavior and Human Decision Processes,

42, 88-110.
Bernstein. E., & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale. Journal of Nervous and Mental Disease,174, 727-735.
Bliss, E.L. (1980). Multiple personalities: A report of 14 cases with implications for schizophrenia and hysteria. Archives of General Psychiatry, 37, 1388-1397.
Bliss, E.L. (1984). Spontaneous self-hypnosis in multiple personality disorder. Psychiatric Clinics of North America 7,135-148.
Bliss, E.L. (1986). Multiple personality, allied disorders, and hypnosis. New York: Oxford University Press.
Boon, S., & Draijer, N. (1993). Multiple personality disorder in the Netherlands: A study on reliability and validity of the diagnosis. Amsterdam: Swets & Zeitlinger.
Braun, B.G. (1980). Hypnosis for multiple personalities. In H. Wain (Ed.), Clinical hypnosis in medicine (pp. 209-217). Chicago: Year Book Medical.
Braun, B.G. (1984). Hypnosis creates multiple personality: Myth or reality? International Journal of Clinical and Experimental Hypnosis, 32, 191-197.
Braun, B.G. (1986). Treatment of multiple personality disorder. Washington, DC: American Psychiatric Press.
Braun, B.G. (1989). Iatrophilia and iatrophobia in the diagnosis and treatment of MPD. Dissociation, 2, 66-69.
Breuer, J., & Freud, S. (1955). On the psychical mechanisms of hysterical phenomena: Preliminary communication. In Strachey, J. (Ed. and Trans.), Standard edition of the complete psychological works of Sigmund Freud, vol. 2 (pp. 259-333). (Original publication, 1893/5)
Briere, J., & Conte, J. (1933). Self-reported amnesia for abuse in adults molested as children. Journal of Traumatic Stress, 6, 21-31.
Brown, D. (1995). Pseudomemories, the standard of science, and the standard of care in trauma treatment. American Journal of Clinical Hypnosis, 37, 1-24.
Coons, P.M. (1980). Multiple personality: Diagnostic considerations. Journal of Clinical Psychiatry, 41, 330-336.
Coons, P.M. (1986). Treatment progress in 20 patients with multiple personality disorder. Journal of Nervous and Mental Disease, 174, 715-721.
Coons, P.M. (1989). Iatrogenic factors in the misdiagnosis of multiple personality disorder. Dissociation, 2, 70-76.
Coons, P.M. (1994). Confirmation of childhood abuse in childhood and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. Journal of Nervous and Mental Disease, 182, 461-464.
Coons, P.M., & Milstein, V. (1986). Psychosexual disturbances in multiple personality: Characteristics, etiology, treatment. Journal of Clinical Psychiatry, 47, 106-110.
Coons, P.M., & Milstein, V. (1994). Factitious or malingered multiple personality disorder: Eleven Cases. Dissociation, 7, 81-85.
Ditto, P.H., & Lopez, D.F. (1992). Motivated skepticism: Use of differential decision criteria for preferred and non-preferred conclusions. Journal of Personality and Social Psychology, 63, 568-584.
Fahy, T.A. (1988). The diagnosis of multiple personality disorder: A critical review. British Journal of Psychiatry, 153, 597-606.
Feldman-Summers, S., & Pope, K. (1994). The experience of "forgetting" childhood abuse: A national survey of psychologists. Journal of Consulting and Clinical Psychology, 62, 636-639.
Festinger, L. (1957). A theory of cognitive dissonance. Stanford: Stanford University Press.
Fine, C.G. (1989). Treatment errors and iatrogenesis across therapeutic modalities in MPD and allied dissociative disorders. Dissociation, 2, 77-82.
Fine, C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. Psychiatric Clinics of North America, 14, 661-675.
Fine, C.G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), Clinical perspectives on multiple personality disorder (pp. 135-153). Washington, DC: American Psychiatric Association.

© M.E.G.-Stiftung

Fink, D. (1991). The comorbidity of multiple personality disorder and DSM-III-R axis II disorders. Psychiatric Clinics of North America, 14, 547-566.
Frankel, F.H. (1992). Adult reconstruction of childhood events in the multiple personality disorder literature. American Journal of Psychiatry, 150, 954-958.
Freud, S. (1962). Charcot. In Strachey, J. (Ed. and Trans.), The complete psychological works of Sigmund Freud, vol. 3 (pp. 7-23). London: Hogarth. (original work published in 1893)
Greaves, G.B. (1989). Observations on the claim of iatrogenesis in the promulgation of MPD: A discussion. Dissociation, 2, 99-104.
Greaves, G.B. (1993). A history of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), Clinical perspectives on multiple personality disorder (pp. 355-380). Washington, DC: American Psychiatric Press.
Harriman, P. (1942). The experimental production of some phenomena of multiple personality. Journal of Abnormal and Social Psychology, 37, 244-255.
Herman, J.L. (1992). Trauma and recovery. New York: Basic Books.
Herman, J.L., & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. Psychoanalytic Psychology, 4, 1-14.
Hilgard, E.R. (1977/1986). Divided consciousness: Multiple controls in human thought and action. New York: Wiley. (Expanded edition, 1986)
Hornstein, N.L., & Putnam, F.W. (1992). Clinical phenomenology of child and adolescent multiple personality disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 31, 1055-1077.
Kampman, R. (1976). Hypnotically induced multiple personality: An experimental study. International Journal of Clinical and Experimental Hypnosis, 24, 215-227.
Kluft, R.P. (1982). Varieties of hypnotic interventions in the treatment of multiple personality. American Journal of Clinical Hypnosis, 24, 230-240.
Kluft, R.P. (1984a). Treatment of multiple personality disorder. Psychiatric Clinics of North America, 7, 9-29.
Kluft, R.P. (1984b). Aspects of the treatment of multiple personality disorder. Psychiatric Annals, 14, 51-55.
Kluft, R.P. (1985a). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), Childhood antecedents of multiple personality (pp. 197-238). Washington, DC: American Psychiatric Press.
Kluft, R.P. (1985b). Making the diagnosis of multiple personality disorder (MPD). In F.F. Flach (Ed.), Directions in Psychiatry (pp. 1-11). New York: Hatherleigh.
Kluft, R.P. (1986). Personality unification in multiple personality disorder (MPD): A follow-up study. In B.G. Braun (Ed.), Treatment of multiple personality disorder (pp. 29-60). Washington, DC: American Psychiatric Press.
Kluft, R.P. (1987a). An update on multiple personality disorder. Hospital and Community Psychiatry, 38, 363-373.
Kluft, R.P. (1987b). Making the diagnosis of multiple personality disorder. In F.F. Flach (Ed.), Diagnostics and psychopathology (pp. 207-225). New York: Norton.
Kluft, R.P. (1987c). The simulation and dissimulation of multiple personality disorder. American Journal of Clinical Hypnosis, 30, 104-118.
Kluft, R.P. (1987d). Unsuspected multiple personality disorder: An uncommon source of protracted resistance, interruption, and failure in psychoanalysis. Hillside Journal of Clinical Psychiatry, 9, 100-115.
Kluft, R.P. (1988a). On treating the older patient with multiple personality disorder: "Race against time or make haste slowly?" American Journal of Clinical Hypnosis, 30, 257-266.
Kluft, R.P. (1988b). The phenomenology and treatment of extremely complex multiple personality disorder. Dissociation, 1(4), 47-58.
Kluft, R.P. (1988c). On giving consultations to therapists treating MPD: Fifteen years' experience - Part 1 (Diagnosis and treatment). Dissociation, 1 (3), 23-29.

Kluft, R.P. (1989a). Iatrogenic creation of new alter personalities. Dissociation, 2, 83-91.
Kluft, R.P. (1989b). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. American Journal of Clinical Hypnosis, 32, 90-98.
Kluft, R.P. (1991a). Multiple personality disorder. In A. Tasman & S.M. Goldfinger (Eds.), American Psychiatric Press annual review of psychiatry (Vol. 10, pp 161-188). Washington, DC: American Psychiatric Press.
Kluft, R.P. (1991b). Clinical presentations of multiple personality disorder. Psychiatric Clinics of North America, 14, 605-629.
Kluft, R.P. (1991c). The hospital treatment of multiple personality disorder. Psychiatric Clinics of North America, 14, 695-719.
Kluft, R.P. (1992). Enhancing the hospital treatment of dissociative disorder patients by developing nursing expertise in the application of hypnotic techniques without formal trance induction. American Journal of Clinical Hypnosis, 34, 158-167.
Kluft, R.P. (1992a). The use of hypnosis with dissociative disorders. Psychiatric Medicine, 10, 31-46.
Kluft, R.P. (1992b). Hypnosis with multiple personality disorder. American Journal of Preventive Psychiatry and Neurology, 3, 19-27.
Kluft, R.P. (1993a). The treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. Dissociation, 6, 87-101.
Kluft, R.P. (1993b). The initial stages of psychotherapy in the treatment of multiple personality disorder patients. Dissociation, 6, 145-161.
Kluft, R.P. (1993c). Basic principles in conducting the psychotherapy of multiple personality disorder. In R.P. Kluft, & C.F. Fine (Eds.), Clinical perspectives on multiple personality disorder (pp. 19-50). Washington, DC: American Psychiatric Press.
Kluft, R.P. (1994a). Treatment trajectories in multiple personality disorder. Dissociation, 7, 63-76.
Kluft, R.P. (1994b). Applications of hypnotic interventions. Hypnos, 21, 205-223.
Kluft, R.P. (1995a). Reflections on current controversies surrounding dissociative identity disorder. In L.M. Cohen, M.R. Elin, & J.N. Berzoli (Eds.), Dissociative identity disorder (pp. 347-377) Northvale, NJ: Jason Aronson, Inc.
Kluft, R.P. (1995b). The confirmation and disconfirmation of memories of abuse in dissociative identity disorder patients: A naturalistic clinical study. Dissociation, 8, 253-258.
Kluft, R.P. (in press a). An overview of the treatment of patients alleging that they have suffered ritualized or sadistic abuse. In G.A. Fraser (Ed.), The phenomenon of ritualized abuse. Washington, DC: American Psychiatric Press.
Kluft, R.P. (in press b). The argument for the reality of the delayed recall of trauma. IN P.S. Appelbaum, L. Uyehara, & M. Elin (Eds.), Trauma and memory: Clinical and legal controversies.
Kooper, C., Classen, C., & Spiegel, D. (1994). Predictors of posttraumatic stress symptoms among survivors of the Oakland/Berkeley Firestorm. American Journal of Psychiatry, 151, 888-894.
Kuhn, T.S. (1970). The structure of scientific revolutions, 2nd ed. Chicago: University of Chicago Press.
Loftus, E. (1993). The reality of repressed memories. American Psychologist, 48, 518-537.
Leavitt, H.C. (1947). A case of hypnotically produced secondary and tertiary personalities. Psychoanalytic Review, 34, 274-295.
Kooper, C., Classen, J., & Spiegel, D. (1994). Predictors of posttraumatic stress symptoms among survivors of the Oakland/Berkeley Firestorm. American Journal of Psychiatry,151, 888-894.
Loewenstein, R.J. (1991a). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. Psychiatric Clinics of North America, 14, 567-604.
Loewenstein, R.J. (1993). Posttraumatic and dissociative aspects of transference and countertransference in the treatment of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), Clinical perspectives on multiple personality disorder (pp. 511-85). Washington, DC: American Psychiatric Press, 1993.
Marmer, S.S. (1980). Psychoanalysis of multiple personality. International Journal of Psychoanalysis, 61, 677-693.

© M.E.G.-Stiftung

Mersky, H. (1992). The manufacture of personalities: The production of multiple personality disorder. British Journal of Psychiatry, 160, 327-340.
McHugh, P.R. (1993). Multiple personality disorder. The Harvard Mental Health Letter, 10 (3), 4-6.
Putnam, F.W. (1989). Diagnosis and treatment of multiple personality disorder. New York: Guilford.
Ross, C.A. (1989). Multiple personality disorder: Clinical phenomenology, diagnosis, and treatment. New York: Wiley.
Ross, C.A., Norton, G.R., & Fraser, G.A. (1989). Evidence against the iatrogenesis of multiple personality disorder. Dissociation, 22, 61-65.
Ross, C.A., Norton, G.R. (1989). Effects of hypnosis on the features of multiple personality disorder. American Journal of Clinical Hypnosis, 32, 99-106.
Ross, C.A. (1994, June). Debating myself. Paper presented at the Eastern Regional Conference on Abuse and Multiple Personality Disorder, Alexandria, Virginia.
Sargent, W., & Slater, E. (1941). Amnestic syndromes in war. Proceedings of the Royal Society of Medicine, 34, 757-764.
Spanos, N.P., Weekes, J.R., & Bertrand, L.D. (1985). Multiple personality: A social psychological perspective. Journal of Abnormal Psychology, 94, 362-376.
Spanos, N.P., Weekes, J.R., Menary, E., & Bertrand, L.D. Hypnotic interview and age regression in the elicitation of multiple personality symptoms: A simulation study. Psychiatry, 49, 298-311.
Spiegel, D. (1986). Dissociating damage. American Journal of Clinical Hypnosis, 29, 123-131.
Spiegel, D. (1991). Dissociation and trauma. In A. Tasman & S. Goldfinger (Eds.), American Psychiatric Press annual review of psychiatry, vol. 10 (pp. 261-266). Washington, DC: American Psychiatric Press.
Spiegel, H., & Spiegel, D. (1978). Trance and treatment. New York, Basic Books.
Stengel, E. (1943). Further studies on pathological wandering (fugues with the impulse to wander). Journal of Mental Health Science , 89, 224-241.
Steinberg, M. (1993a). Clinical interview for the diagnosis of DSM-IV dissociative disorders. Washington, DC: American Psychiatric Press.
Steinberg, M. (1993b). Interviewer's guide to the clinical interview for the diagnosis of DSM-IV dissociative disorders. Washington, DC: American Psychiatric Press.
Watkins, J.G., & Watkins, H.H. (1993). Ego-state therapy in the treatment of dissociative disorders. In R.P. Kluft & C.G. Fine (Eds.), Clinical perspectives on multiple personality disorder (pp. 277-299). Washington, DC: American Psychiatric Press.
Williams, L.M. (1992). Adult memories of childhood abuse: Preliminary findings from a longitudinal study. The APSAC Advisor (Summer), 19-21.
Williams, L.M. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. Journal of Consulting and Clinical Psychology , 62, 1167-1176.
Woodruff, R.A., Goodwin, D.W., & Guze, S. (1974). Psychiatric diagnosis. New York: Oxford University Press.

Acknowlegement:

This contribution is largely drawn from my more extensive treatment of the subject in Reflections on Current Controversies Surrounding Dissociative Identity Disorder, a chapter for Multiple Personality Disorder: Diagnosis and Therapy, edited by Lewis M. Cohen, M.D., Mark R. Elin, Ph.D., and Joan N. Berzoli, and published in 1995 by Jason Aronson Publishers, of Northvale, New Jersey. This talk was written before the publication of this book, but relied on the same materials.