24 The Long Struggle to Diagnose Multiple Personality Disorder (MPD): MPD

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OUTLINE

What is multiple personality disorder (MPD) and how do we diagnose it? The modern dissociative disorders field has struggled with these questions for the past 25 years. This chapter brings together the different strands of this effort and argues that the literature on MPD contains robust answers to these questions that are not contained in the modern Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1980, 1987, 1994, 2000).

MPD received considerable scientific attention in the late 1800s, but scientific interest in MPD underwent a lengthy interregnum from about 1910 to 1980 (Rosenbaum, 1980). MPD was "rediscovered" by clinicians in the 1970s, many of whom gathered careful data on their cases. Curiously, there is a notable difference between what these clinicians learned about MPD and what has been portrayed in the DSM (e.g., Coons, 2001; Kluft, 1985a; Peterson & Putnam, 1994; Ross, 1997).

Similarly, there is a large gap between what the scientific research literature says about MPD and what is portrayed in the DSM (Dell, 2006b).

24.1 MPD AND THE DSM

MPD was formally returned to scientific attention in 1980 when several significant papers on MPD were published (Bliss, 1980; Coons, 1980; Greaves, 1980; Marmar, 1980; Rosenbaum, 1980). That same year, MPD received the imprimatur of the American Psychiatric Association. Whereas DSM-II (APA, 1968) had listed multiple personality as a symptom of Hysterical Neurosis, Dissociative Type, DSM-III (APA, 1980) "elevated [MPD] from the position of symptom to disorder" (Coons, 1989, p. 1).

24.1.1 MPD AND DSM-III

The DSM-III Dissociative Disorders Work Group was dominated by clinical experts on MPD. These experts devised a set of diagnostic criteria for MPD that set the DSM on a path from which it has never deviated. Specifically, the DSM presents a definition of MPD rather than a typical set of diagnostic criteria (i.e., signs and symptoms).

24.1.1.1 DSM-III Criteria for MPD

A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time.
B. The personality that is dominant at any particular time determines the individual's behavior.
C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships. (DSM-III, p. 259)

The DSM-III diagnostic criteria for MPD are oddly at variance with the core mission of DSM-III. Because DSM-II had generated such poor levels of diagnostic reliability, the raison d'être of DSM-III was to devise criteria that would improve diagnostic reliability (Spitzer, Williams, & Skodol, 1980). The diagnostic criteria in DSM-III were mandated to consist of (1) well-defined, unambiguous clinical phenomena, and (2) specific inclusion and exclusion criteria (Spitzer, Endicott, & Robins, 1975). If the subsequent controversy about MPD has shown anything, it is that the criteria for MPD are neither well-defined nor unambiguous.[1] I consider the DSM criteria for MPD to be lethally abstract. Subsequent revisions of the DSM have made some adjustments to these criteria, but the 1980 diagnostic criteria for MPD remain fundamentally unchanged. Even the 1994 amnesia criterion for MPD is just another abstract definition: "Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness" (DSM-IV, p. 487).

The issue that I am raising here is not the correctness or accuracy of the criteria, but their ambiguity, their high level of abstraction, and worst, their lack of usefulness to the average clinician. The criteria for other disorders in DSM-IV are often models of detail, specificity, and concreteness: (1) Major Depressive Disorder: "depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)…" (DSM-IV, p. 327); (2) Panic Attack: "A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes: palpitations, pounding heart, or accelerated heart rate; sweating, trembling or shaking; sensations of shortness of breath or smothering; feeling of choking; chest pain or discomfort; nausea or abdominal distress; feeling dizzy, unsteady, lightheaded, or faint; derealization (feelings of unreality) or depersonalization (being detached from oneself); fear of losing control or going crazy; fear of dying; paresthesias (numbness or tingling situations); chills or hot flushes" (DSM-IV, p. 395); (3) Posttraumatic Stress Disorder (PTSD): "The traumatic event is persistently reexperienced in one (or more) of the following ways: …" (DSM-IV, p. 428).[2]

24.1.2 MPD AND DSM-III-R

The DSM-III-R Dissociative Disorders Work Group wrestled with at least six issues regarding MPD: (1) clinical inaccuracies in the DSM-III diagnostic criteria, (2) whether to make the criteria more restrictive, (3) whether to add an amnesia criterion, (4) whether to totally revise the

[1] One reviewer hoped that I meant this statement to refer only to DSM-III—because, otherwise, I might be understood to be claiming that "MPD is not a clearly defined condition." Unfortunately, with regard to the DSM diagnostic criteria for MPD/DID, that is precisely what I mean. The criteria in DSM-III, DSM-III-R, DSM-IV, and DSM-IV-TR are unremittingly vague. They have left the average clinician to view MPD only as "through a glass, darkly."

[2] To be fair, it should be noted that the criteria for PTSD have suffered from ambiguous (and shifting) definitions of trauma/traumatization.

criteria, (5) putative cross-cultural forms of MPD, and (6) the boundary between MPD and partial forms of MPD.

24.1.2.1 DSM-III-R Criteria for MPD

A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these personalities or personality states recurrently take full control of the person's behavior. (DSM-III-R, p. 273)

24.1.2.1.1 Clinical Inaccuracies in the DSM-III Criteria

In a landmark paper on the natural history of MPD, Kluft (1985b) convincingly argued that the DSM-III criteria for MPD were inaccurate in several ways. His arguments appear to have convinced the DSM-III-R Dissociative Disorders Work Group; the Work Group incorporated into the revised criteria several of his recommended changes (Kluft, 1987a; Kluft, Steinberg, & Spitzer, 1988). In recognition of the phenomena of passive influence and copresence, DSM-III-R's criteria for MPD no longer required one personality to be dominant at any given time.[3] Recognizing that (1) alters vary in their complexity and elaboration, and (2) different persons' systems or complexes of alters have different styles of operation, DSM-III-R no longer required each personality to be "complex and integrated with its own unique behavior patterns and social relationships" (DSM-III, p. 259).[4]

24.1.2.1.2 Should the Criteria for MPD Be More Specific?

At the time of the deliberations of the DSM-III-R Dissociative Disorders Work Group (i.e., 1986–1987), there were significant differences of opinion in the dissociative disorders field about whether the diagnostic criteria for MPD should be more specific and, hence, more diagnostically restrictive. Kluft (1982, 1985) and Bliss (1980) advocated less restrictive criteria; Braun (1985), Coons (1984), Loewenstein (Loewenstein & Putnam 1990), and Putnam (2001) advocated more restrictive criteria. The subcommittee chose to make the DSM-III-R criteria for MPD less specific and less diagnostically restrictive than the DSM-III criteria that they replaced:

> The argument that carried the day was that DID was seriously underdiagnosed and that having a few, very general criteria would encourage its diagnosis. It was also argued (primarily on the basis of experience with a few atypical/questionable cases) that there were variants of the disorder, who would be inappropriately excluded if the diagnostic criteria were made more specific. (Putnam, 2001, p. 48)

I think that this reasoning (i.e., that diagnostic recognition of persons with MPD would be increased if the diagnostic criteria were made less specific) was substantially incorrect. In my opinion, the primary diagnostic problem regarding persons with MPD is *not* that clinicians rule out a diagnosis of MPD on the basis of the (restrictive) clinical inaccuracies in the DSM-III diagnostic criteria for MPD (or on the basis of clinicians' incorrect stereotypes of MPD/DID). Yes, both of these frequently happen, but I think that the primary problem is that the average clinician simply does not know what MPD patients really look like (i.e., their typical signs and symptoms)—and DSM-III and DSM-III-R failed (and DSM-IV continues to fail) to delineate the typical signs and symptoms of MPD patients.

24.1.2.1.3 Should Amnesia Be a Diagnostic Criterion for MPD?

The amnesia issue has been a bone of contention for every Dissociative Disorders Work Group (i.e., DSM-III, DSM-III-R, and DSM-IV). Coons, Loewenstein, and Putnam have been longstanding advocates of the need for an amnesia criterion (Coons, 1980, 1984; Loewenstein & Putnam, 1990). Kluft has been an equally longstanding opponent of the amnesia criterion (Kluft, 1985b; Putnam, 2001; Spiegel & Cardeña, 1991). Kluft argued that amnesia was difficult to detect because it fluctuated and because the patient often defensively denied it or truly did not remember it (i.e., the patient has amnesia for his/her amnesia). In the DSM-III-R Dissociative Disorders Work Group,

[3] "Criterion B is potentially confusing. The personality that appears to be dominant and may represent itself as dominant may in fact be strongly influenced by another, of whose influence it may or may not be aware … [T]he personalities' experiences of one another's impact may take the form of hallucinations, illusions, and passive influence experiences…" (Kluft et al., 1988, p. 40).

[4] "Criterion C is problematic. The degree of elaboration and complexity of the separate entities has proven to be an expression of the interaction style of the personalities, the structure of the dissociative defenses, overall adaptive patterns, and character style of the individual patient rather than a core criterion of the illness" (Kluft et al., 1988, p. 40).

an amnesia criterion for MPD was voted down; the argument in favor of less restrictive criteria held sway:

> … the inclusion of an amnesia criterion, notwithstanding substantial considerations to the contrary, was considered likely to contribute to the underdiagnosis of such cases. (Kluft, Steinberg, & Spitzer, 1988, p. 41)

Kluft's arguments against adding an amnesia criterion stemmed from his strong concern that MPD was underdiagnosed because clinicians ruled out MPD on the basis of misguided reasons (e.g., an absence of apparent amnesia) and incorrect rules-of-thumb (e.g., if the person remembers what a supposed alter personality did or said, then that person does not have MPD).[5] As stated above, I think that Kluft's concern was correct, but that his concern also amounted to a *de facto* underemphasizing of the average clinician's profound lack of education about the typical presentations of MPD. The DSM should provide that education, but, in my opinion, it has substantially foregone that responsibility by failing to provide the typical diagnostic signs and symptoms of MPD.

24.1.2.1.4 The Boundary Between MPD and Partial Forms of MPD

The boundary between MPD and partial MPD is the crucial exclusionary criterion for MPD.[6] This boundary separates DID from its nearest nosological neighbor (see DDNOS-1[7] in DSM-IV). This nosological boundary was not addressed by DSM-III, perhaps because the existence of partial MPD and other forms of ego state disorder (see Dell, 2009a and Watkins & Watkins, 1997) were little recognized or understood at the time DSM-III was written. In DSM-III, Atypical Dissociative Disorder included trance states, states of derealization, and the effects of brainwashing, but Atypical Dissociative Disorder did not explicitly acknowledge the likely existence of partial forms of MPD. Thus, DSM-III-R was the first DSM to explicitly mention partial forms of MPD. Still, DSM-III-R's handling of partial MPD was, at best, ambivalent. The DSM-III-R Work Group members clearly disagreed about the nosological status of these cases:

> Proposals were received to create separate classifications for patients who have syndromes that have the same structure as Multiple Personality Disorder, but with less overt manifestations, and for children with such a condition in its incipient phase (e.g., Fagan & McMahon, 1984) or in the process of evolving toward the adult form (e.g., Kluft, 1984c, 1985b). The committee acknowledged that these conditions exist and have been documented, but that at this time the evidence remains too preliminary to serve as the basis of new classifications. *Longitudinal data suggests that they may all prove to be phases of the same disorder* (Kluft, 1985a). A decision was made to refer to the differences between adult and childhood cases in the descriptive text for Multiple Personality Disorder, and to include examples under Dissociative Disorder NOS that explicitly acknowledged less overtly manifested conditions. (Kluft, Steinberg, & Spitzer, 1988, p. 44. italics added)

A careful reading of this quotation shows that it does not acknowledge that partial forms of DID actually exist: "they may all prove to be phases of the same disorder." In other words, these new examples of DDNOS may only be "less overtly manifested" cases of MPD.

My sense is that the DSM-III-R Work Group harbored significant differences of opinion about what is and what is not MPD, but that the extant empirical data were too sparse to support any one point of view regarding the boundaries of MPD and partial MPD. So, the Work Group tentatively acceded to the strongly articulated views of the group's *de facto* leader on "matters multiple"—Richard Kluft. Although I think that Kluft was substantially correct, the nosological status of the relationship between MPD and DDNOS-1 (i.e., DDNOS-1-as-a-variant/subtype-of-MPD vs. DDNOS-1-as-a-different-disorder-than-MPD) is still an open question. That nosological question is the topic of Part II of this chapter (Dell, 2008a).

24.1.2.1.5 What Should Be Done About Culture-Bound Dissociative Syndromes?

The committee took note of the large number of culture-bound dissociative syndromes that have no corresponding diagnosis in DSM-III. Some argued that a diagnosis of trance/possession disorder should be added to DSM-III-R so that it would provide a home for many of the

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[5] One reviewer of this chapter averred that Kluft's implicit hypothesis (i.e., that increasing the specificity of the diagnostic criteria would increase the underdiagnosis of DID) has received little support; that is, MPD was underdiagnosed both when the DSM included an amnesia criterion (i.e., DSM-IV and DSM-IV-TR) and when the DSM did not include an amnesia criterion (i.e., DSM-III and DSM-III-R).

[6] The concept of partial MPD is highly important, but it cannot be adequately addressed in the present chapter. Partial MPD (as well as MPD, itself) is inseparable from Watkins's concept of ego state disorders (Watkins & Watkins, 1997). Both ego state disorders and the concept of partial MPD are addressed in detail in the sequel to this chapter: "The long struggle to diagnose multiple personality disorder (MPD): II. Partial MPD" (Dell, 2009a).

[7] DDNOS-1 refers to the first example of dissociative disorder not otherwise specified (DDNOS) in DSM-IV: "1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which a) there are not two or more distinct personality states, or b) amnesia for important personal information does not occur" (p. 490).

culture-bound dissociative syndromes. Ultimately, the Work Group decided not to add such a disorder on the grounds that the culture-bound syndromes closely resembled MPD:

> the close resemblance of many of these syndromes to MPD (Kenny, 1981) argues against such a revision, pending further study. (Kluft, 1987a, p. 423)

24.1.2.1.6 Should the Diagnostic Criteria for MPD Be Totally Revised?

The disposition of this question during the writing of DSM-III-R was, in my view, a fateful one for the dissociative disorders field. With apologies to Robert Frost, this is "the road not taken."

> By the time of the drafting of DSM-III-R, however, a fair amount had been learned about the clinical features of DID. An extensive set of specific criteria based on several, independent, relatively large sample, studies could have been generated. After considerable debate, the committee chose instead to continue with the very general (monothetic) DSM-III profile. (Putnam, 2001, pp. 47–48)

And that has made all the difference. Shortly following the publication of DSM-III-R, all hell broke loose. MPD, the diagnostic criteria for MPD, and the concept of dissociation were subjected to torrents of criticism. Although I think that this backlash had a variety of determinants, I believe that MPD's vague diagnostic criteria in DSM-III and, especially, DSM-III-R helped to fuel the backlash (see Dell, 2001c).

24.1.3 DID[8] AND DSM-IV

24.1.3.1 DSM-IV Criteria for DID

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these identities or personality states recurrently take control of the person's behavior.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. (DSM-IV, p. 529)

The DSM-IV Dissociative Disorders Work Group wrestled with at least four issues regarding DID: (1) whether to change the name of the disorder, (2) whether to add an amnesia criterion, (3) whether to totally revise the diagnostic criteria, and (4) the nature of the boundary between DID and partial forms of DID. First and foremost, however, it is essential to recognize that the DSM-IV Dissociative Disorders Work Group was deeply divided:

> By the time that the DSM-IV was being drafted, DID was deeply mired in controversy—which continues to this day. The political need to "balance" the committee with proponents and critics, who were then forced to conduct meetings by conference call, insured virtual paralysis. (Putnam, 2001, p. 48)

24.1.3.1.1 Should the Name of the Disorder Be Changed?

Many subcommittee discussions wrestled with the question of whether to change the name of the disorder:

> The issue that almost exclusively dominated the discussion was whether or not to change the name of multiple personality disorder to something else—with many alternatives being proposed and rejected. Although the committee consistently voted against name changes, one was imposed anyway.[9] (Putnam, 2001, p. 48)

Ultimately, three of the four specific dissociative disorders underwent a name change (i.e., Dissociative Amnesia, Dissociative Fugue, and Dissociative Identity Disorder), thereby bringing the names of the first two into closer accord with the International Classification of Disease-10 (ICD-10), but, ironically, distancing Dissociative Identity Disorder from the ICD-10, which continues to use the term *multiple personality disorder.*

24.1.3.1.2 Should DID Have an Amnesia Criterion?

The debate about an amnesia criterion for MPD was taken up again by the DSM-IV Dissociative Disorders Work Group. As before, Kluft argued that such a criterion would lead to underdiagnosis of DID. This time, he was outvoted: an amnesia criterion was adopted for DID:

> On the basis of … research [Ross et al., 1989; Putnam et al., 1986; Bliss, 1984] that shows the very high incidence of amnesic symptoms among MPD patients, the risk of making false negative diagnoses seems remote,

[8] DSM-IV changed the name of MPD to Dissociative Identity Disorder (DID), as described in the following.

[9] By the chair of the Work Group.

> particularly when the professional is sensitized to the association between amnesia and dissociation. (Spiegel & Cardeña, 1991, p. 372)

Perhaps as a result of the strained conditions of the Work Group's functioning, something odd occurred: the Work Group developed a false memory. The Work Group's debate about an amnesia criterion somehow became a debate about whether to *reinstate* DSM-III's amnesia criterion for MPD. There never was an amnesia criterion for MPD in DSM-III. Still, DSM-IV's Appendix D (Annotated Listing of Changes in DSM-IV) incorrectly states: "The DSM-III requirement that there be an inability to recall important personal information has been reinstated" (p. 784).

24.1.3.1.3 Should the Diagnostic Criteria for DID Be Totally Revised?

Here, once again, is "the road not taken." The DSM-III-R Work Group had voted to retain MPD's broad, abstract diagnostic criteria. Now, 7 years later, more research data on MPD had accumulated. The data easily could have enabled the development of a polythetic[10] set of diagnostic criteria for MPD. But that did not happen. The opportunity to develop specific, polythetic criteria was lost again, apparently a casualty of the Work Group's stormy functioning:

> The "amnesia" criterion was added, but other attempts to increase criterion specificity stalled amid the contention, confusion, and inertia of the group. (Putnam, 2001, p. 48)

24.1.3.1.4 The Boundary Between DID and Partial Forms of DID

As noted, the boundary between DID and partial DID is the crucial exclusionary criterion for DID; it defines what is, and what is not, DID. DSM-IV suggested that two features distinguish between DID and partial DID: (1) amnesia, and (2) the distinctness of the parts or alters (see Footnote 8 for DSM-IV's description of DDNOS-1).

Despite the vagueness of its characterization, DSM-IV's DDNOS-1 is an important advance; the DSM is starting to delineate the boundary between DID and its nearest nosological neighbor.

Curiously, the DSM-IV Work Group did not address a major nosological problem that affects DSM-III's classification of the dissociative disorders. Three epidemiological investigations of the dissociative disorders (Mezzich et al., 1989; Saxe et al., 1993; Saxena & Prasad, 1986) had reported a disproportionate number of DDNOS cases; that is, 57% to 90% of the dissociative disorders in those three epidemiological investigations were diagnosed as DDNOS. The DSM-IV Work Group bequeathed this nosological problem to the next (i.e., DSM-V) Dissociative Disorders Work Group:

> One of the greatest challenges for editors of future editions of the DSM will be to obtain greater taxonomical clarity, considering that the majority of diagnosed dissociative disorders do not fit the established criteria. (Spiegel & Cardeña, 1996, p. 235)

24.2 WHY THE MODERN DSM HAS PROVIDED ONLY A STRUCTURAL DEFINITION OF DID

For 28 years, the modern DSM has given clinicians only a structural definition of DID (Dell, 2001a, 2001c). This definition of DID is tautological: "If multiple personalities/identities are present, then the person has DID." The DSM provides no guidance about *how* to identify persons with DID—just the preceding tautological guideline: "When multiple personalities are present, make a diagnosis of DID." Efforts within the Work Group to increase the specificity of the diagnostic criteria by adding signs and symptoms have been consistently voted down—on the grounds that those additional criteria would be too restrictive and lead to false negative diagnoses of MPD/DID. Thus, since 1980, Criterion A for DID has remained essentially unchanged: "The presence of two or more distinct identities or personality states…" (DSM-IV, p. 487). From the perspective of such a structural definition of DID, it does not matter which dissociative symptoms are present (or not present). It only matters that multiple personalities/identities be present:

> what is essential to multiple personality disorder across its many presentations is no more than the presence, within an individual, of more than one structured entity with a sense of its own existence. (Kluft, 1985b, p. 231)

Richard Kluft has been to DID what Kraepelin and Bleuler were to schizophrenia. Many of his papers are

[10] The concept of polythetic classes was first advanced by a biologist, Michael Beckner, in 1959. Polythetic classes are defined by a large number of characteristics, none of which is considered to be necessary. Polythetic diagnostic criteria are widely considered to be more accurate than monothetic diagnostic criteria (i.e., a small number of characteristics, all of which are necessary). Polythetic and monothetic diagnostic criteria are described in detail in the next section of this chapter.

monuments of descriptive psychiatry, especially his chapter on the natural history of MPD (from which the above quotation is drawn). In that chapter, Kluft documented why he believes that efforts to increase the specificity of the diagnostic criteria for MPD would undermine the diagnosis of MPD. He argued that the symptoms of persons with MPD vary widely—across persons with MPD and across time in each person with MPD. Accordingly, Kluft (1985b) opposed DSM criteria that were more specific or more behavioral. He insisted that "definitions and criteria based on behavioral evidence may misrepresent multiple personality disorder as it actually occurs" (p. 231). Most important, however, Kluft reported in that same article that most cases of MPD were hidden, rather than overt. He argued convincingly that *overt display of alter personalities is neither essential nor typical of MPD*:

> Approximately 15 percent of adult patients are diagnosed when they dissociate spontaneously during assessment or therapy. Another 40 percent show some subtle form of classic signs that could alert the clinician to multiple personality disorder if he or she has an index of suspicion for the condition, and has seen the subtle signs of switching that one observes during the treatment of such patients. The remaining 40 percent show no classic signs of multiple personality disorder and are diagnosed either serendipitously, when the clinician makes a strong effort to pursue diagnostic clarity, when ancillary information raises the issue, or when personalities suppressed in session try to get the clinician to see what is going on. (Kluft, 1985b, pp. 218–219)

Why is overt display of alter personalities not basic to MPD? Kluft (1985a, 1985b) provided a plethora of reasons. Kluft (1985b) noted (1) that alters "often passed for one another" (p. 205), (2) that alters often come and go so quickly "that the only trace they left was a brief fluctuation in facial expression" (p. 205), and (3) that the emergence of personalities (i.e., switching) is often quite infrequent: "Often several months passed during which personalities did not emerge fully" (p. 205). He also noted that the alter personalities of child cases were often indistinct, "muted or attenuated" (p. 213), and that the alter personalities of adult cases were often relatively invisible because they were "uninvested and unmotivated in being conspicuously separate" (p. 213). Finally, Kluft deftly reminded the reader that MPD exists for certain reasons, and that those reasons seldom include a need to display their presence:

> The *raison d'être* of multiple personality disorder is to provide a structured dissociative defense against overwhelming traumata. The emitted observable manifestations of multiple personality disorder are epiphenomena and tools of the defensive purpose. In terms of the patients needs, the personalities need only be as distinct, public, and elaborate as becomes necessary in the handling of stressful situations. (Kluft, 1985b, p. 231)

No wonder DID can be so difficult to diagnose. No wonder many clinicians do not notice that some of their patients have other personalities. No wonder that so many clinicians and scholars are skeptical or unaware of the existence of this disorder. Kluft's take-home message in this regard is incisive (and profoundly important for the diagnosis of MPD/DID):

> the mental health disciplines have come to expect as normative what in fact is a relatively unusual presentation: florid, overt, and unconcealed multiple personality disorder. (Kluft, 1985b, p. 211)

In my opinion, this observation is so true that clinicians who routinely treat DID hardly notice it anymore; the hiddenness of MPD patients is as noticeable to them as the air that they breathe. In fact, I believe that complete switching (from one personality to another) is actually one of the least frequent phenomena of DID (Dell, 2006b, 2009a, 2009b).[11]

So, how does this bear upon "the long struggle to diagnose MPD"? Here, I think, Kluft's solution to the problem of MPD hiddenness has taken us astray. As noted, he has counseled that the DSM diagnostic criteria should cleave to what is essential about MPD: "the presence, within an individual, of more than one structured entity with a sense of its own existence" (Kluft, 1985b, p. 231). From Kluft's point of view, even the DSM-IV criteria are too restrictive: the diagnostic criteria for DID should be *just* Criterion A and Criterion B:

> A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

[11] For a potentially different point of view, see Loewenstein, Hamilton, Alagna, Reid, and deVries (1987). Their experiential sampling study with a single DID patient during a 3-month hospitalization at NIMH found switching to be frequent during the first month (11 switches per day) and less frequent during the third month (3 per day). It is not known whether these findings (based on a single patient who was undergoing intensive, long-term, inpatient treatment for DID) are typical of the day-to-day functioning of persons with DID who are not being treated for DID.

B. At least two of these identities or personality states recurrently take control of the person's behavior. (DSM-IV, p. 487)

As a characterization of the essence of our classical concept of DID, I think that criteria A and B are fine. As diagnostic criteria, I think they are a disaster. Criteria A and B are largely useless to the average clinician; they provide no signs or symptoms of DID. They leave the average clinician almost groping in the dark. As Brenner (2001) has quietly observed, "the revised diagnostic criteria of the DSM-IV do not greatly help the average clinician" (p. 38).

24.3 DISADVANTAGES OF THE CURRENT DIAGNOSTIC CRITERIA FOR DID

There is a science of classification that has guided zoologists (Beckner, 1959; Sneath, 1962; Sneath & Sokal, 1973), philosophers (Wittgenstein, 1953), and psychiatric nosologists (Blashfield, 1986; Cantor, French, Smith, & Mezzich, 1980; Frances & Widiger, 1986; Livesley, 1985; Spitzer, Endicott, & Robins, 1978). This science of classification was brought to bear on the writing and rewriting of most of the diagnostic criteria in the modern DSM—but not the diagnostic criteria for DID (Dell, 2001a, 2001c).

The distinction between monothetic and polythetic classes has been particularly influential on the modern DSM.

> Monothetic classification is based on a simple conceptual strategy; it organizes data according to (what are considered to be) the predominant or compelling features of the members of the class.... In a monothetic class, *every defining feature is essential*. Each member of a monothetic class must possess *all* of the class's defining characteristics. (Dell, 2001a, pp. 10–11)

Monothetic classification belongs mostly to "the early days" (Sokal, 1966, p. 107) of an area of investigation. In keeping with this view, Blashfield contends that monothetic diagnoses are poorly formulated and rarely used:

> Generally the categories that are given monothetic definitions are those that have poorly formulated diagnostic criteria (e.g., depersonalization disorder) and/or those categories that are rarely used in applied clinical practice (e.g., pyromania). (Blashfield, 1986, p. 374)

Monothetic classes have many disadvantages—not least of which is the annoying inconvenience that the natural world is rarely monothetic (Bailey, 1973; Kendell, 1975). For psychiatric nosologists, there are three major disadvantages of monothetic classification: (1) monothetic classification ignores many other features of the category or class in question, (2) monothetic classes produce a high rate of false-negative diagnoses (Widiger, Frances, Spitzer, & Williams, 1988), and (3) monothetic classes generate an artifactually low base-rate of the disorder (Clark, Watson, & Reynolds, 1995). DID is one of the few disorders in DSM-IV that still uses monothetic diagnostic criteria.

The justification for the unadorned simplicity of DID's Criterion A and Criterion B was that greater specificity would lead to false-negative diagnoses of DID. Yet, critics of monothetic classification note that monothetic classes *always* increase false negative diagnoses (Eysenck, 1986; Frances, Pincus, Widiger, Davis, & First, 1994; Livesley, 1985; Sneath & Sokal, 1973; Wittgenstein, 1953). From one perspective, both are correct. If more behavioral criteria are added to a *monothetic* class, the class will become still narrower and false negative diagnoses will increase. But from another perspective, only one side is correct. If more behavioral and symptom criteria are added *and* the class is changed from a monothetic one to a polythetic one, then the class will become broader and false negative diagnoses will decrease. The current monothetic criteria for DID are a genuine problem. The critics of monothetic classes are correct. Monothetic classes increase false-negative diagnoses and produce an artifactually low base-rate of the disorder.

The bottom line is that DID needs polythetic diagnostic criteria. Polythetic classes afford behavioral specificity *without* increasing false-negative diagnoses.

Most disorders in DSM-IV have polythetic criteria (or monothetic/polythetic hybrids wherein monothetic criteria are specified polythetically). Borderline personality disorder (BPD), for example, has polythetic criteria. A person can be diagnosed with BPD when any five of BPD's nine criteria are present. PTSD, on the other hand, has three monothetic criteria (i.e., reexperiencing, avoidance/numbing, and hyperarousal) each of which is specified polythetically. Thus, in PTSD, any one of five types of reexperiencing must be present; *and* any three of seven types of avoidance/numbing must be present; *and* any two of five kinds of hyperarousal must be present.[12]

[12] Strictly speaking, this paragraph is an oversimplification because it addresses only the core clinical diagnostic criteria for BPD and PTSD. In fact, BPD has six monothetic criteria, and its first criterion has nine polythetic items. BPD's other five monothetic criteria are those that must be satisfied by each personality disorder in the DSM. Similarly, PTSD has six monothetic criteria, of which reexperiencing, avoidance/numbing, and hyperarousal are the second, third, and fourth.

As noted, the mandate of the modern DSM (i.e., DSM-III and later) was to increase diagnostic reliability by (1) eliminating abstract criteria that are too susceptible to idiosyncratic interpretations by different clinicians, and (2) increasing the behavioral and symptomatic specificity of the diagnostic criteria. Polythetic elaboration of monothetic criteria has been a frequent vehicle for achieving behavioral and symptomatic specificity in the modern DSM. The larger number of features that are typical of polythetic criteria (e.g., 9 criteria for BPD, 17 criteria for PTSD) are scientifically important. Within limits, the more features that a polythetic class is based upon, the more predictive that class will be—both of external correlates of the class and of internal correlates of the class (Sneath & Sokal, 1973; Sokal, 1966).

Although the purpose of the DSM is to provide "guidelines for making diagnoses" (DSM-IV-TR, p. xxxvii), *the DSM does not provide guidelines for diagnosing DID.* Even researchers despair about the criteria for diagnosing DID:

> What is the gold standard for the diagnosis of multiple personality disorder? There has been a change of diagnostic criteria for multiple personality disorder over time from DSM-III to DSM-III-R and now to DSM-IV. We are still uncertain as to what specific clinical criteria should be used to make the diagnosis, not to mention research diagnostic criteria for multiple personality disorder. (Latz, Kramer, & Hughes, 1995, p. 1348)

Instead, it provides definitions—of DID, of switching, and of amnesia. Thus, for 25 years, the DSM has provided almost no signs or symptoms for diagnosing DID. As such, the DSM's criteria for DID cannot be considered to be user-friendly:

> The DSM-IV criteria for DID are *profoundly* unfriendly to the average clinician. Criteria A, B, and C (especially Criterion C) for DID are so abstract as to be almost indecipherable, and hence, substantially unusable. (Dell, 2001a, p. 20)

The most convincing evidence that the DSM provides little guidance for diagnosing DID may be the fact that experts on DID have universally composed longer lists of diagnostic symptoms of DID (Bliss, 1986; Boon & Draijer, 1993b; Braun, 1988; Coons, Bowman, & Milstein, 1988; Dell, 2006b; Fraser, 1994; Horevitz, 1994; Kluft, 1985a, 1987, 1999; Loewenstein, 1991; Loewenstein, Hornstein, & Farber, 1988; Putnam, 1989, 1993, 1997; Ross, 1997; Spira, 1996; Steinberg, 1995). In contrast, experts on depression or anxiety do not construct their own personal lists of diagnostic symptoms for DSM-IV disorders; the DSM provides excellent explications of major depressive episodes, panic attacks, and so on.

The fact that experts on DID have routinely compiled their own lists of DID symptoms is an indication that the DSM-IV diagnostic criteria for DID have *poor content validity.* When applied to diagnostic criteria, "content validity refers to the extent that the criteria of a disorder represent the domain of symptoms associated with that disorder" (Blashfield & Livesley, 1991, p. 266). The DSM-IV diagnostic criteria for DID poorly represent the domain of symptoms of DID (Dell, 2006b; see also Table 24.1).

TABLE 24.1
Thirteen Well-Documented Dissociative Symptoms of Dissociative Identity Disorder

Symptom	Empirical Studies
Straightforward dissociative symptoms	
1. Amnesia	32
2. Conversion	28
3. Voices	22
4. Depersonalization	20
5. Trances	17
6. Self-alteration	16
7. Derealization	14
8. Awareness of the presence of alters	10
9. Identity confusion	10
10. Flashbacks	8
Psychotic-like dissociative symptoms	
11. Auditory hallucinations	13
12. Visual hallucinations	11
13. Some Schneiderian first-rank symptoms*	14
'Made' actions	6
Voices arguing	5
Voices commenting	4
'Made' feelings	3
Thought withdrawal	2
Thought insertion	2
'Made' impulses	1

Note: Empirical studies = the number of empirical studies that have reported the occurrence of that dissociative symptom in persons with Dissociative Identity Disorder. This Table has been adapted from A new model of dissociative identity disorder, by P.F. Dell, 2006, *Psychiatric Clinics of North America, 29*, pp. 1–26. Copyright 2006 by Elsevier B. V. Adapted with permission.

* These passive-influence Schneiderian symptoms are correlated with DID. Three remaining Schneiderian symptoms (i.e., audible thoughts, thought broadcasting, and delusional perceptions) are not correlated with DID.

As noted, monothetic diagnostic criteria are founded upon "the predominant or compelling features of the members of the class" (Dell, 2001a, p. 10). In the case of DID, the predominant or compelling feature is "the presence of two or more distinct identities or personality states … that recurrently take control of the person's behavior" (DSM-IV, p. 529). This monothetic focus on distinct identities and switching has a very serious disadvantage; namely, *distinct-identities-who-switch (i.e., florid DID) is an uncommon event in the lives of persons with DID* (Dell, 2006b; Kluft, 1985b). In fact, visible switching from one alter to another probably ranks among the least frequent phenomena of DID (Dell, 2006b, 2008a, 2008b; Kluft, 1985b). So, why base the diagnosis of DID solely upon an infrequent and difficult-to-discern sign of the disorder?[13] No wonder so many clinicians have been skeptical that DID really exists.[14]

The problems with diagnosing DID also reside in the names of the disorder: *multiple personality disorder, dissociative identity disorder.* Other names have been proposed. Kluft (1988) once suggested calling the disorder "disaggregate self-state disorder," which I actually think is quite accurate. My own favorite name for DID is "dissociative self-state disorder." Still, there is a problem with all of these names; they focus *solely* on personalities, identities, self-states, and so on.

Over the past few decades, it has become increasingly clear that DID is characterized by much more than alter personalities. Persons with DID routinely exhibit a vast array of dissociative symptoms. In other words, DID is more than an alter disorder; it is a chronic complex dissociative disorder. Coons (2001), for example, has argued that DID needs a name that "truly reflects the polysymptomatic nature of DID" (p. 44). In keeping with this understanding, Dell (2001a) has suggested renaming DID *major dissociative disorder* and Coons (2001) has suggested *pervasive dissociative disorder.* Perhaps the most common referent or label for DID (other than MPD or DID) is "complex dissociative disorder." To my knowledge, no one has actually proposed that DID be renamed *Complex Dissociative Disorder*,[15] but variations of this term have been cropping up in the literature with increasing frequency: "chronic complex dissociative disorders" (Ross, 1990), "complex chronic dissociative symptoms" (Loewenstein, 1991), "complex posttraumatic and dissociative disorders" (Chu, 1998), "chronic, complex dissociative disorder" (Tutkun et al., 1998, p. 804), "complex dissociative disorders" (Coons, 2001), and "the taxon of chronic complex dissociative disorder" (Ross, Duffy, & Ellason, 2002, p. 15). Clearly, the authors cited in this paragraph understand DID to be much more than just "an alter disorder." They understand DID to be a major, pervasive, complex, chronic, dissociative disorder. Perhaps the DSM should call DID *Complex Dissociative Disorder.*

Finally, it should be noted that many DID scholars have expressed dissatisfaction with the DSM-IV diagnostic criteria for DID (Coons, 2001; Coons & Chu, 2000; Dell, 2001a, 2001c, 2006b; Nakdimen, 1992, 2006; Putnam, 1997; Ross, 1997; Steinberg, 2001). These critics have been quite explicit in faulting the DSM criteria for (1) their vagueness, (2) their failure to cover the polysymptomatic presentation of DID, (3) their failure to reflect the empirical literature on DID, and (4) their contribution to the controversiality that has surrounded DID, and (5) their obstruction of research. For example:

> Focusing on the polysymptomatic nature of DID and DDNOS with other ego states would do what the name change from "multiple personality disorder" to "dissociative identity disorder" was only mildly successful in doing—emphasizing the cross-cultural aspects of complex dissociative disorders and de-emphasizing the fascination of clinicians, patients, and the lay public and press for the sensational aspects of alternate personality states. (Coons, 2001, p. 44)

> I believe that the portrayal of … DID in The Diagnostic and Statistical Manual of Mental Disorders has been (1) an unnoticed obstacle to progress in the dissociative

[13] I am *not* asserting that some people with DID do not switch. Although I actually believe that the frequency, context, and visibility of switching is a matter of individual style—including the possibility of a style of not switching at all (see, for example, the case described by Fraser, 1994)—I am not making that case here. I am simply stating that infrequent and hidden switching is characteristic of the vast majority of persons with DID. And that this (1) typically has negative consequences for diagnosis, and (2) has helped to provoke skepticism about DID.

[14] I do not claim that skepticism about the existence of DID is solely due to putative inadequacies or deficiencies in the DSM's diagnostic criteria for the disorder. There are many other reasons for skepticism, including starkly countertransferential ones. In any case, the present chapter is not an analysis of skepticism about DID. Instead, this chapter is an analysis of the history and, I believe, the deficiencies of the modern DSM's diagnostic criteria for DID. I address skepticism regarding DID only in so far as it may relate to clinicians' encounters with the interface between (1) typical clinical presentations of DID, and (2) the DSM's diagnostic criteria for DID.

[15] In the interim between when this chapter was written and its final proofreading, Richard Lowenstein has proposed using the term Complex Dissociative Disorder.

> disorders field, and (2) an indirect contributor to the field's loss of credibility. (Dell, 2001c, p. 4)
>
> Although I served on both the DSM-III-R and DSM-IV dissociative disorder work groups, I have strong reservations about the diagnostic criteria specified by the DSM for MPD/DID. More stringent, better-operationalized criteria for MPD can readily be devised. (Putnam, 2001, p. 94).

First, Pincus, Levine, Williams, Ustun, and Peele (2004) have suggested that DSM-III, DSM-III-R, and DSM-IV collectively addressed the issue of diagnostic reliability and validity. First et al. believe that DSM-V should continue to focus on validity, but that it should give priority to clinical utility.

As the time for DSM-V approaches, the DSM-IV criteria for DID still portray a 1980-vintage disorder; the diagnostic criteria for DID have not progressed beyond what was barely acceptable in DSM-III. Consequently, the diagnostic criteria for DID are now badly out of step with the rest of DSM-IV. Worse, the DSM's abstract monothetic criteria for DID have done the opposite of what was intended; *the DSM's diagnostic criteria have undermined the diagnostic reliability of DID*:

> DID has not been lifted by the rising tide of diagnostic reliability; the everyday reliability of the diagnosis of DID is abysmal. It is true that, when used by trained researchers and clinicians, the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R) and the Dissociative Disorders Interview Schedule (DDIS) have excellent reliability for the diagnosis of DID.… There is little evidence, however, that the diagnosis of DID is reliable when it is made (or not made) by the average clinician who uses (only) DSM-IV or DSM-IV-TR. (Dell, 2001a, p. 9)

I think that researchers in the dissociative disorders field have been almost reluctant to report data that compare the diagnoses of average clinicians with the diagnoses of dissociative disorder experts. Comparative reports provoke the skeptics of DID who consider such data to be further evidence of the "outrageous" and "dubious" diagnostic practices of those who "believe in" DID.

Still, there is considerable *sotto voce*[16] evidence that the diagnostic practices of the average clinician differ considerably from those of dissociative disorder researchers. First, the comparative difference in diagnostic practices is part of the daily experience of clinicians who treat DID (and interact with other clinicians). Second, although no study has rigorously compared and reported the diagnostic practices of the average clinician versus those of experts on DID, the essential study has actually been conducted many times. Studies of the prevalence of DID in inpatient settings implicitly compare the diagnoses of average clinicians with those of DID experts, but those data are seldom reported in a focal way. For example, a review of 12 inpatient prevalence studies shows that one article clearly reported and discussed comparative diagnostic data, four tangentially provided comparative data but did not discuss it, and seven reported no comparative data at all. In many of these papers, however, the authors implied (or the reader was left to infer) that the unit's regular psychiatrists seldom diagnosed DID.

I contend that the time has come for the DSM-V Dissociative Disorders Work Group to develop well-specified, polythetic diagnostic criteria for DID (and the other dissociative disorders). Such criteria would accomplish two essential goals: (1) they would make it much easier for the average clinician to correctly identify cases of DID; and (2) they would greatly increase the everyday diagnostic reliability of the disorder.

24.4 DEVELOPING POLYTHETIC DIAGNOSTIC CRITERIA FOR DID

At the present time, there seem to be two alternative paths for developing polythetic criteria for DID: (1) develop polythetic criteria for DSM-IV DID, or (2) develop polythetic criteria for DID-as-a-complex-dissociative-disorder.

24.4.1 Polythetic Criteria for DSM-IV DID

Table 24.2 delineates a polythetic elaboration of (1) "two or more distinct identities or personality states," that (2) "recurrently take control of the person's behavior," and (3) are accompanied by an "inability to remember important personal information."

Because I disagree with DSM-IV's concept of DID, I did not make an extensive effort to elaborate and refine Criterion A and Criterion B (Table 24.2). On the other hand, I consider Criterion C to be a *sine qua non* for DID (and most of the dissociative disorders). Accordingly, I have invested much time and thought in Criterion C's polythetic elaboration of amnesia. This polythetic elaboration of Criterion C not only illustrates the amnesia of persons with DID; it also provides the clinician with a set of implicit diagnostic inquiries about amnesia.

[16] *Sotto voce*. Italian. "Spoken softly or in an undertone so as not to be overheard."

TABLE 24.2
A Polythetic Elaboration of DSM-IV's Diagnostic Criteria for DID

A. At least one additional distinct personality or personality state is present, as evidenced by three (or more) of the following:
   (1) the personality or personality state has its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self as manifested by affect, opinions, and/or attitudes
   (2) the personality or personality state appears to be noticeably different from the person's customary self as manifested by two (or more) of the following:
      (i) facial expression
      (ii) body posture
      (iii) tone of voice
      (iv) mannerisms
      (v) affect
      (vi) opinions
      (vii) attitudes
   (3) the personality or personality state claims/perceives itself to be a different part or a different person from another part of the person
   (4) the individual perceives/claims that the personality or personality state is "not me"
   (5) the individual is subjectively aware of the existence of separate parts 'inside'

B. At least two identities or personality states recurrently take control of the person's behavior, as evidenced by one (or more) of the following:
   (1) the individual is witnessed (by the clinician or a collateral informant) to undergo a transition (i.e., a 'switch') from one distinct personality or personality state to another as evidenced by one (or more) of the following:
      (i) an announced change of identity (e.g., "I'm not *her*, I'm Janice.")
      (ii) a relatively sudden change of self-presentation as manifested by two (or more) of the following:
         (a) facial expression
         (b) body posture
         (c) tone of voice
         (d) mannerisms
         (e) affect
         (f) opinions
         (g) attitudes
   (2) the individual exhibits dissociative amnesia for the activities of another personality or personality state (as witnessed by the clinician or described by a collateral informant)

C. Incidents of dissociative amnesia that are reported by the person or a collateral informant, as evidenced by at least three (or more) incidents of the following:
   (1) discovering that one has 'lost' a chunk of time; being completely unable to account for a period of time—hours or longer—including the loss of memory for up to years of his/her life
   (2) "coming to": suddenly discovering that he/she was in the middle of doing something that he/she did not remember initiating (e.g., conversing with someone, disciplining the children, cooking dinner, etc.) or suddenly discovering that he/she had done something he/she does not remember doing (e.g., smashed something, cut self, cleaned the whole house)
   (3) fugues: suddenly discovering that he/she was somewhere with no memory of having gone there in the first place (e.g., finding self at the mall, at the beach, in one's car, under the bed, in a closet, etc.)
   (4) being told of things that he/she had recently done, but having no memory of doing those things
   (5) finding objects among his/her possessions or in his/her shopping bags—that he/she does not remember acquiring, purchasing, or producing (e.g., shoes, clothes, toys, toilet articles, drawings, handwritten materials, etc.)
   (6) finding evidence of his/her recent actions, but with no memory of having done those things (e.g., mowed the lawn, completed a task at work, cleaned the house, changed one's apparel or hairstyle or cosmetics, having a significant injury—a cut, a burn, many bruises, having attempted suicide)
   (7) not remembering who he/she is or what her or his name is
   (8) being unable to remember well-established skills (e.g., how to read, how to drive, how to play the piano, how to do his/her job, etc.)
   (9) other incidents of being unable to recall personal information that is so unlikely or so extensive that it cannot be explained by ordinary forgetfulness

A well-described amnesia criterion is absolutely crucial to the diagnosis of DID and other dissociative disorders (Friedl, Draijer, & de Jonge, 2000).

Before presenting an alternative path to developing diagnostic criteria for DID, I want to review four reasons why I do *not* recommend that the DSM-V Dissociative Disorders Work Group pursue a polythetic elaboration of the DSM-IV criteria for DID (as in Table 24.2). First, the DSM-IV criteria are completely centered on alter identities/personalities. Alter personalities are immersed in a pervasive cloud of dissociative symptoms, but the diagnostic criteria completely ignore this cloud of symptoms (Dell, 2001a, 2006b). Second, the modern DSM's alter-centric approach to DID fuels controversy about the disorder (Dell, 2001c).

Third, the DSM-IV criteria focus on switching, but switching is infrequent and difficult-to-discern (Dell, 2006b; Kluft, 1985b). As Kluft (1985b) has noted, 94% of MPD patients try to hide or dissimulate their pathology. It simply does not make sense to make the diagnosis of DID completely dependent upon such an infrequent and elusive phenomenon.

Fourth, the DSM-IV criteria omit the most common symptoms of DID: ongoing intrusions into the executive functioning and sense of self of the person (Dell, 2006b, 2009a, 2009b). These intrusions have previously been described in terms of first-rank symptoms (Kluft, 1985a, 1987b), passive influence phenomena (Kluft, 1985a, 1987b), process symptoms of DID (Loewenstein, 1991; Putnam, 1993, 1997; Putnam & Loewenstein, 2000), and secondary features of DID (Ross, 1997). If I were to use the "control-language" of the modern DSM, then I would characterize these intrusions as incidents of partial control of the host by another personality (who influences the host "from within" rather than completely emerging or switching).

These intrusions and influences are especially important for diagnosis. They are vastly more frequent than switching and they answer a question that Kluft (1985b, p. 203) asked (and answered) 20 years ago: "What does multiple personality disorder look like when it does not look like multiple personality disorder as one expects to see it?" In other words, what does MPD look like when the personalities are not switching? What does MPD look like most of the time?

> Well-disguised adult patients often present with nothing more to suggest multiple personality disorder than affirmative answers to inquiry about passive influence or special hallucination experiences, the Schneiderian first rank symptoms. (Kluft, 1985b, p. 222)

Elizabeth Bowman (personal communication, 8-15-05) notes that intrusions are characteristic of both DID and DDNOS-1 (and other ego state disorders), but that switching has special diagnostic significance because only persons with DID switch. I completely agree. Yet, I do not agree that the diagnosis of DID should always wait upon an observed incident of switching. Why? Because switching is so often hidden, so often limited to private contexts (e.g., home alone), so infrequent, and so difficult-to-discern that many (most?) DID patients are unreasonably penalized because their undetectable switching deprives them of the correct diagnosis and the correct treatment.

I completely agree that the diagnostic criteria for DID should include switching, but I contend that those diagnostic criteria should also include an alternative diagnostic criterion to switching: recurrent incidents of amnesia. Recurrent incidents of amnesia are a potent indicator of switching. Accordingly, I contend that recurrent incidents of recent amnesia is a valid alternative to switching as an indicator of DID.

24.4.2 DSM-IV DID Is a Culturally Biased Portrayal of Complex Dissociative Disorders

The incidence of Western-style DID in non-Western cultures is low, especially in Asian cultures (Adityanjee, Raju, & Khandelwal, 1989; Alexander, Joseph, & Das, 1997; Takahashi, 1990; Umesue, Matsuo, Iwata, & Tashiro, 1996). Such cultures breed a different kind of self and foster different expressions of dissociative psychopathology (Martínez-Taboas, 1991; Takahashi, 1990; Umesue et al., 1996). There is little doubt that the DSM's nosology of the dissociative disorders is biased toward the dissociative disorders that are familiar to American psychiatrists (i.e., dissociative presentations that are common to North America and Western Europe; Das & Saxena, 1989; Saxena & Prasad, 1989; Wig, 1983). If the DSM is ever to achieve accordance with the ICD, then it will probably be necessary for the American Psychiatric Association to present a version of DID that is much less culturally biased. As Ross (1990) has noted, "There are probably cultures in which chronic, complex dissociative disorders take forms other than MPD" (p. 64).[17]

[17] I further contend that the names, *dissociative identity disorder* and *multiple personality disorder*, are themselves culturally biased because they reflect the Western concept of self. DID should have a name that is culturally neutral.

24.4.3 Polythetic Criteria for Complex Dissociative Disorder

Table 24.1 summarizes the empirical literature on the dissociative symptoms of DID. There are 13 well-documented dissociative symptoms of DID (Table 24.1; see Dell, 2006b).[18] The DSM-IV diagnostic criteria for DID contain only 2 of these 13 dissociative symptoms: (1) amnesia, and (2) awareness of the presence of alters. DSM-IV, of course, does not actually require that the patient be *aware* of the presence of alters—only that alters be present. The other 11 well-documented dissociative symptoms of DID in Table 24.1 are absent from the DSM-IV diagnostic criteria. In contrast, Table 24.3's proposed criteria for Complex Dissociative Disorder include all 13 of these well-documented symptoms.[19]

The diagnostic criteria for Complex Dissociative Disorder[20] have three monothetic elements[21] that are elaborated polythetically: (A) classic dissociative symptoms, (B) conscious awareness of influences-from-within, and (C) recurrent amnesia.

[18] Table 24.1 has a major shortcoming; it does not indicate how common these symptoms are in DID. Instead, Table 24.1 indicates how often these symptoms have been reported in the scientific literature on DID. Thus, a symptom could be noted in numerous studies, but be found in only 5% to 10% of patients in the literature that is summarized by Table 24.1. Similarly, a symptom could be noted in a small number of studies, but be present in more than 90% of patients in those studies. Part of the problem is that, prior to the development of the Multidimensional Inventory of Dissociation (MID; Dell, 2006a), no instrument could simultaneously assess and compare the incidence of the 13 dissociative phenomena in Table 24.1. Table 24.4, however, reports the MID-assessed incidence of Table 24.1's dissociative phenomena (and other dissociative phenomena) in 41 SCID-D-diagnosed persons with DID.

[19] The criteria for Complex Dissociative Disorder incorporate the literature's reports of "auditory hallucinations" and "visual hallucinations" under the headings of child voices, persecutory voices, internal struggle, and posttraumatic flashbacks. Visual images of alter personalities are not directly reflected in the criteria for Complex Dissociative Disorder, but they are assessed by the MID.

[20] I proposed an earlier version of these diagnostic criteria under the name of *Major Dissociative Disorder* (Dell, 2001a).

[21] The three monothetic elements of Complex Dissociative Disorder were chosen for two reasons: (1) they provide comprehensive coverage of the dissociative symptoms of DID/Complex Dissociative Disorder; and (2) they provide a template that encompasses every kind of dissociative presentation. Persons with DID manifest classic dissociative symptoms, intrusions, and amnesia. Persons with DDNOS-1 manifest primarily classic dissociative symptoms and intrusions. Finally, persons with nondissociative disorders manifest primarily classic dissociative symptoms. The complete dissociative profiles of many disorders are still substantially unknown (e.g., depersonalization disorder, dissociative amnesia, dissociative fugue, posttraumatic stress disorder, borderline personality disorder, etc.).

24.5 EMPIRICAL TESTS OF TABLE 24.3'S POLYTHETIC CRITERIA FOR COMPLEX DISSOCIATIVE DISORDER

Three studies have tested slightly different versions of the diagnostic criteria in Table 24.3. In a pilot study of the Multidimensional Inventory of Dissociation (MID; Dell, 2006a), which assesses all but two of the above diagnostic criteria (i.e., B1 and C1), 91% of 34 persons with DSM-IV DID met the above diagnostic criteria (Dell, 2001b). The remaining 9% of the 34 DID cases (N = 3) were diagnosed as DDNOS-1b.[22] Persons were diagnosed as DDNOS-1b if they met Criterion A and Criterion B, but not Criterion C. Of the 34 persons with DSM-IV DID, 97% met Criterion A, 100% met Criterion B, and 91% met Criterion C.[23] The internal consistency of scores on the above diagnostic symptoms was calculated for 203 research participants (i.e., nonclinical adults, patients with no dissociative disorder, DDNOS-1b patients, and DID patients). Scores on the above diagnostic symptoms had a Cronbach alpha coefficient of 0.99 (Dell, 2001b).

In a much larger MID study of 220 DSM-IV cases of DID, 87% met the above criteria: 93% met Criterion A, 93% met Criterion B, and 94% met Criterion C (Dell, 2006b). In this study, the MID assessed 23 of the above symptoms; the 220 DID cases had a mean of 20.2 of the 23 symptoms. Table 24.4 shows the incidence of 24 of the proposed dissociative symptoms of Complex Dissociative Disorder in 41 SCID-D-diagnosed persons with DID (Dell, 2006b). The Cronbach alpha coefficient of scores on these symptoms was 0.98.

Finally, Gast, Rodewald, Dehner-Rau, Kowalewsky, Engl, Reddemann, and Emrich (2003) used the German translation of the MID to compare SCID-D diagnoses with MID diagnoses. In their research sample (of DID patients, DDNOS-1 patients, nondissociative psychiatric patients, and nonclinical adults), Gast and colleagues reported that a slightly different version of the diagnostic criteria in Table 24.3 had a positive predictive power of 0.93, a negative predictive power of 0.84, and an overall

[22] DDNOS-1b refers to a subset of the cases that DSM-IV describes in the first example of DDNOS: "1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which…b) amnesia for important personal information does not occur" (p. 490).

[23] Nine percent of these DSM-IV DID cases did not meet the MID criterion for the presence of amnesia. Two possible explanations for this occurrence are (1) a genuine, reduced incidence of amnesia due to psychotherapy or (2) a false denial of amnesia (which reflects some DID patients' denial of the reality or extent of their clinical condition).

TABLE 24.3
Diagnostic Criteria for Complex Dissociative Disorder*

A. Classic dissociative symptoms, as indicated by three (or more) of the following:
   (1) Circumscribed amnesia for autobiographical memory (e.g., cannot remember childhood before age 12; no memory of age 9-11; no memory of an important life event such as getting married, giving birth, or grandmother's funeral)
   (2) Depersonalization (e.g., feeling detached/distant from self; body feeling unreal or not all there; feeling separate from self and/or watching self from outside one's body)
   (3) Derealization (e.g., feeling disconnected/distant from everything; surroundings feel strange, unreal, oddly different; not recognizing familiar people or places)
   (4) Posttraumatic flashbacks (e.g., re-experiencing some or all of the sensory elements of a past trauma)
   (5) Somatoform symptoms (e.g., motor symptoms, sensory alterations, genital pain without physical explanation)
   (6) Trance (e.g., recurrent involuntary episodes of staring off into space, being 'gone' from conscious awareness, and unresponsive to environmental stimuli)

B. The person has conscious awareness of the intrusions/influences from another self-state, as indicated by either (1) or (2):
   (1) Switching without concomitant amnesia: The clinician or a collateral informant witnesses a self-state that claims (or appears) to be someone other than the person in question, as indicated by a, b, and c:
      (a) The visible presence of a different self-state, as evidenced by one (or more) of the following:
         (i) an announced change of identity (e.g., "I'm not her; I'm Janice.")
         (ii) a relatively sudden change of self-presentation as manifested by changes in two (or more) of the following:
            (1) facial expression
            (2) body posture
            (3) tone of voice
            (4) mannerisms
            (5) affect
            (6) opinions
            (7) attitudes
      (b) the person's conscious awareness of that self-state, as evidenced by both of the following three features: the person's
         (i) reported co-conscious awareness of the activities of that other self-state
         (ii) subsequent remembering of what the other self-state said and did
      (c) the person reports experiencing that self-state as "other," "not me," or not self
   (2) The person has conscious awareness of intrusions/influences from another self-state, as indicated by five (or more) of the following:
      (a) hearing the voice of a child in his/her head
      (b) noticing an internal struggle (that may or may not involve voices that argue). Note: internal struggle goes well beyond ambivalence; it involves a sense of the presence of different parts that are strongly opposing one another.
      (c) hearing a persecutory voice (usually in the head) that comments harshly, makes threats, or commands self-destructive acts
      (d) speech insertion (unintentional or disowned utterances)
      (e) thought insertion or withdrawal
      (f) 'made' or intrusive feelings and emotions (or sudden withdrawal/absence of feelings and emotions)
      (g) 'made' or intrusive impulses
      (h) 'made' or intrusive actions (i.e., actions that are perceived/experienced as depersonalized) or actions or behaviors that are blocked actions
      (i) atypical experiences of self-alteration (e.g., feeling very physically small or mentally young like a young child; having emotions, thoughts, or feelings that don't feel like they belong to oneself; seeing someone else instead of oneself in the mirror, etc.)
      (j) self-puzzlement secondary to 2a–2i

C. Recurring incidents of amnesia secondary to intrusions by another self-state, as indicated by either (1) or (2):
   (1) Switching that is accompanied by amnesia: The clinician or a collateral informant witnesses a self-state that claims (or appears) to be someone other than the person being interviewed, followed by the person's subsequent amnesia for what the other self-state was witnessed to do or say, as evidenced by a and b.
      (a) the visible presence of a different self-state, as evidenced by one (or more) of the following:
         (i) an announced change of identity (e.g., "I'm not her; I'm Janice.")

(Continued)

TABLE 24.3
Diagnostic Criteria for Complex Dissociative Disorder* *(Continued)*

(ii) a relatively sudden change of self-presentation as manifested by changes in two (or more) of the following:
(1) facial expression
(2) body posture
(3) tone of voice
(4) mannerisms
(5) affect
(6) opinions
(7) attitudes

(b) amnesia: the person is subsequently unable to recall what the other self-state said and did

(2) Recurring incidents of amnesia, as indicated by the person's report of two (or more) incidents of two (or more) of the following:
(a) discovering that he/she has amnesia for a discrete interval of time ('lost time'): being completely unable to account for a period of time—an hour or longer—including the loss of memory for up to years of one's life)
(b) "coming to": discovering that he/she was in the middle of doing something that he/she did not remember initiating (e.g., conversing with someone, disciplining the children, cooking dinner, performing occupational tasks, etc.) or suddenly discovering that he/she had done something he/she does not remember doing (e.g., smashed something, cut self, cleaned the whole house, etc.)
(c) fugues: suddenly discovering that he/she was somewhere with no memory of having gone there in the first place (e.g., finding self at the mall, at the beach, in one's car, under the bed, in a closet, etc.)
(d) being told of things that he/she had recently done, but with no memory of having done those things
(e) finding objects among his/her possessions or in his/her shopping bags—that he/she does not remember acquiring, purchasing, or producing (e.g., shoes, clothes, toys, toilet articles, drawings, handwritten materials, etc.)
(f) finding evidence of his/her recent actions, but with no memory of having done those things (e.g., mowed the lawn, produced written work, completed a task at work, cleaned the house, changed one's apparel or personal appearance, having a significant injury—a cut, a burn, many bruises, having attempted suicide, etc.)
(g) not remembering who he/she is or what her/his name is
(h) being unable to remember well-established skills (e.g., how to read, how to drive, how to play the piano, how to do his/her job, etc.)
(i) other incidents of being unable to recall personal information that is so unlikely or so extensive that it cannot be explained by ordinary forgetfulness.

D. The disturbance is not better accounted for by Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Mood Disorder With Psychotic Features, or Borderline Personality Disorder and is not due to the direct physiological effects of a substance (e.g., a drug or substance of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

* Although all of these diagnostic criteria are assessed by the MID (see Dell, 2006a, 2006b, and 2009b), they are obviously too extensive and too complex to function as diagnostic criteria for DSM-V. Possible new diagnostic criteria for DID are currently being contemplated by the Dissociative Disorders Research Planning Conferences and the American Psychiatric Association's DSM-V Task Force.

predictive power of 0.89 for diagnosing major dissociative disorder (i.e., DID or DDNOS-1).

In Gast's et al. sample, the Cronbach alpha coefficient for scores on the MID's 23 diagnostic symptoms was 0.98. Thus, the diagnostic symptoms in Table 24.4 cluster together almost perfectly (Cronbach alpha values of 0.98 to 0.99). A self-report instrument that is based on these criteria (i.e., the MID) was able to do an excellent job of diagnosing DID in two studies (Dell, 2001b, 2006b) and major dissociative disorder (i.e., DID or DDNOS-1) in another study (Gast et al., 2003). These findings suggest that the criteria listed previously have much to recommend them.

Finally, the findings of these three MID studies have a provocative implication. When I originally proposed the diagnostic criteria for DID, I predicted that these criteria would make it possible to diagnose DID "*before* unambiguous contact with alters has been established" (Dell, 2001a, p. 26). Two studies have now shown that this is, indeed, possible (Dell, 2001b, 2006b). In other words, *if the diagnostic criteria for DID are based on the full range of dissociative symptoms that occur in DID, it is possible to reliably and validly diagnose DID before unambiguous contact has been made with alter personalities*. It is possible to do this because, in addition to switching, DID has a pathognomonically distinctive pattern of dissociative symptoms.

TABLE 24.4
Incidence of 24 Dissociative Symptoms of Complex Dissociative Disorder in 41 SCID-D DID Cases

A. Classic dissociative symptoms	
1. Circumscribed autobiographical amnesia	83%
2. Depersonalization	95%
3. Derealization	93%
4. Posttraumatic flashbacks	93%
5. Somatoform symptoms	83%
6. Trance	88%
B. Intrusions/influences from another self-state	
1. Child voices	95%
2. Internal struggle	100%
3. Persecutory voice	88%
4. Speech insertion	85%
5. Thought insertion/withdrawal	93%
6. 'Made' feelings	95%
7. 'Made' impulses	85%
8. 'Made' actions	98%
9. Experiences of self-alteration	98%
10. Self-puzzlement	98%
C. Amnesia	
1. Time loss	88%
2. Coming to	78%
3. Fugues	83%
4. Being told of things done/said	85%
5. Finding objects among possessions	61%
6. Evidence of one's recent actions	71%
7. Not remembering name/identity	68%
8. Forgetting a well-rehearsed skill	93%

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