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The Manufacture of Personalities
The Production of Multiple Personality Disorder

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Unprecedented numbers of cases of MPD have been diagnosed, mainly in North America, since 1957. Widespread publicity for the concept makes it uncertain whether any case can now arise without being promoted by suggestion or prior preparation. In order to determine if there is any evidence that MPD was ever a spontaneous phenomenon, a series of cases of MPD from the earlier literature has been examined, with particular attention given to alternative diagnoses which could account for the phenomena reported and to the way in which the first alternate personality emerged. The earlier cases involved amnesia, striking fluctuations in mood, and sometimes cerebral organic disorder. The secondary personalities frequently appeared with hypnosis. Several amnesic patients were trained with new identities. Others showed overt iatrogenesis. No report fully excluded the possibility of artificial production. This indicates that the concept has been elaborated from the study of consciousness and its relation to the idea of the self. The diagnosis of MPD represents a misdirection of effort which hinders the resolution of serious psychological problems in the lives of patients.

The current clinical picture of multiple personality disorder

Multiple personality disorder (MPD) is defined in DSM–III–R as:

> "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 behaviour." (American Psychiatric Association, 1987)

Putnam (1989), one of the authors of this definition, says that there is a patient profile which should suggest MPD. The core features are a profusion of psychiatric, neurological and medical symptoms, a host of diagnoses, and a failure to respond to treatment for those diagnoses. The symptoms include depressed mood, suicidal attempts and ideas, impaired concentration, fatigue, sexual difficulties, crying spells, and insomnia. Often there is enough superficially to suggest the diagnosis of major affective disorder. Nightmares are prominent, along with terrifying hypnagogic and hypnopompic hallucinations. Closer inquiry discloses that the depression is more liable than is usual with major affective illnesses and that there may be several mood swings each day. Amnesia or 'time loss' may affect as many as 90%, and fugue episodes and feelings of depersonalisation occur in more than 50%. There is sleepwalking in many subjects, anxiety, phobic symptoms, substance abuse, and hallucinations during the day as well. Self-mutilation occurs in about a third of patients. The life history is almost always marked by sexual abuse. A great majority of patients are women.

Some patients declare their diagnosis. Otherwise says Putnam, (1989, p. 90), the therapist who wishes to "elicit alter personalities" should ask gentle questions about whether the patient has ever felt like more than one person, searching for another part, and ultimately asking "Do you ever feel as if you are not alone, as if there is someone else or some other part watching you?" In the event of a response the therapist looks for "any . . . attribute, function or description to use as a label to elicit this other part directly". This is a very clear and honest statement, but with such an approach there is a likelihood that the therapist will produce the phenomenon.

The more dramatic examples of this syndrome attract much attention, ranging from *The Three Faces of Eve* (Thigpen & Cleckley, 1957) to an unfortunate 27-year-old waitress in Oshkosh, Wisconsin, who claimed to have 46 different personalities, of whom six were sworn in and gave testimony in a trial (Daniels, 1990). Publicity must also be suspected of producing such events.

Many of these patients have had terrible experiences and awful problems in their lives. The argument of this paper is not whether or not the patients need treatment – they do – but rather under what label and with which ideas.

Questions and controversies

The foregoing picture is sanctioned by DSM–III–R and has many supporters in North America but is

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viewed with scepticism by others and is rarely, if ever, found in Japan (Takahashi, 1990) or Britain. Occasionally clinicians (Allison & Schwarz, 1980; Kluft, 1982) mention patients with 20 or more personalities. DSM-III-R states that 100 personalities can occur in one person. Fahy (1988) argued that the literature lacks information on the reliability of diagnosis, prevalence, or the role of selection bias, that iatrogenic factors may contribute to MPD, and that there is little evidence from genetic or physiological studies to suggest that it represents a distinct psychiatric disorder. Hacking (1986) suggests that the idea of multiple personalities "was largely invented by doctors, but later became a spontaneous way in which to express unhappiness". Aldridge-Morris (1989) calls it an exercise in deception and sees it as a cultural phenomenon.

Some clinicians working on dissociative memory disorders encounter inordinate numbers of cases of MPD. Others report none. Ljungberg (1957) found none among 381 patients with overt hysterical symptoms. In 89 cases of classic dissociative or conversion disorder (Merskey & Buhrich, 1975) I encountered no MPD. In 36 years I found none among many more patients with conversion disorders. One patient dissociated and talked to herself in a detached fashion. In that instance the genesis of MPD was carefully avoided. Another, under the care of a colleague, declared she had reported her multiple personalities to please the doctors who first told her that that was her condition. Mayer-Gross *et al* (1954, 1977) said that multiple personalities were always artificial productions, due to medical attention and literary interest. Sim (1981) likewise gives a sceptical report. Chodoff (1987) noted the rarity of cases in his own practice and that of colleagues. Fahy *et al* (1989) reported a patient who fulfilled the diagnostic criteria for MPD. She had seen the film *The Three Faces of Eve* and read the book *Sybil* (Schreiber, 1973). Directing her attention away from the 'alternate personalities' led to their decline.

With each favourable step in the public discussion, more cases have occurred. The problem is whether MPD represents a valid syndrome. Simpson (1989) remarks critically upon the enthusiasm of its protagonists. Aldridge-Morris (1989) suggests that it is unhelpful to regard it as a discrete clinical entity and that it is being grossly overdiagnosed.

The disproportionate numbers of female patients (e.g. 90% in the report of Ross *et al* (1990)) raise a question as to whether this is a natural phenomenon related to sex or a social product due to earlier ill-treatment or other forces. It may result from abuse of individuals or from encouragement to comply with a special role, or from both such causes.

The increasing numbers of cases

Scepticism about the diagnosis has been increased by this great growth in numbers of cases. The pattern of this growth is noteworthy. The first supposed case of MPD recorded in detail is that of Mary Reynolds of Pennsylvania (Mitchill, 1816; Plumer, 1860; Mitchell, 1888). The initial report by Mitchill (1816) is third-hand and brief. Plumer (1860) described the history six years after the patient's death, from interviews with her relatives. Weir Mitchell described the case again in 1888 from Plumer's report and from the papers of his father, J. K. Mitchell. He also re-interviewed the same relatives as Plumer had consulted. About that time there was lengthy discussion of several cases, especially by Azam (1876, 1887, 1892), Janet (1887, 1888, 1889), James (1890), Prince (1908), and Sidis & Goodhart (1904). Prince (1908) cited some 24 reported cases. He held that in the more fully developed forms the secondary or 'disintegrated' personality would approximate to that of normal life and might pass before the world as mentally healthy.

Hacking (1986) has argued that MPD was created, as it were, in 1875. In the first three-quarters of the 19th century there were only a few notable cases, such as Reynolds'. Thereafter there was much discussion, especially in France where the concepts supported the views of positivist philosophers and psychologists such as Ribot, who gained ascendency in French academia. More cases were described, including the retrospective descriptions in detail by Azam in 1876 of his own case from 1858, by Mitchell of his father's case, and Leonie and others by Janet. After Prince's book in 1908 the numbers increased again. Taylor & Martin (1944) identified 76 cases occurring over 128 years, and suggested there might be as many more.

In 1954 Thigpen & Cleckley reported a case. Their book *The Three Faces of Eve* appeared in 1957, and a film was made of it. From that point cases multiplied. Boor (1982) recognised 79 reports after 1970. DSM-III-R established a category for MPD in 1987. Kluft (1982) mentioned 130 such patients, of whom he had treated 70. Bliss had seen 100 cases, and Jeppsen another 50 (Bliss & Jeppsen, 1985). Putnam *et al* (1986) reviewed 100 cases. Ross (1987) found an incidence of 4.4% among his patients and claimed that MPD can be readily discovered with a reliable and valid screening instrument (Ross, 1989).

A basis for evaluation

In the light of the growth in numbers and some of the increasingly improbable stories associated with

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MPD it seemed worthwhile to seek a further method by which to probe the origin of the phenomenon. One of the most explicit discussions is given by Sutcliffe & Jones (1962). They considered various conceptions of multiple personality; as a diagnostic fashion; as a product of shaping in therapy; as a product of hypnotic suggestion; as simulation; and as an extension of characteristics found in 'normal' personalities.

We now have a strong diagnostic fashion for the topic in some countries. Hypnotic suggestion accompanies innumerable reports. Simulation is always possible but, if therapists can create the condition by suggestion, the need for simulation is slight. Explanation by an 'extension' of normal personalities is disputable since the patterns presented are distinct.

I noticed some examples in which shaping by therapy was the most plausible explanation (Prince, 1908; Janet, 1911) and therefore examined a sample of the literature for information on other diagnoses and on the moments of emergence of secondary personalities. It appeared that the historical context of ideas on the topic might cast light on its growth. This seems the more important because of late the potential for artificial production of the phenomenon has been facilitated by publicity and by DSM-III-R, so that patients appear with foreknowledge of the pattern. This article presents observations on the diagnosis of classic cases and the origins of the extra personalities.

Conceptual presuppositions

Diagnosis in medicine is heuristic and variable (Merskey, 1986). Some diagnoses are preferable to others, because the conditions seem to originate independently of doctors or social demands, or because they are more successful in prognosis or in explaining aetiology, or – most important – because they are the most helpful guides to treatment. They may be influenced by psychological factors or by social expectations, whether we are talking about cancer pain, endogenous depression, or post-traumatic stress disorder. However, it is reasonable to reject those diagnoses which most reflect individual choice, conscious role playing, and personal convenience in problem solving, provided we have alternatives which are less troublesome intellectually, and at least as practical socially and therapeutically, and not morally objectionable. Hence I am evaluating MPD as a diagnosis with the implicit view that certain other diagnoses are acceptable alternatives: mania, certain depressive illnesses, schizophrenia, obsessional neurosis, and even some conversion or dissociative symptoms arise in very many cases of MPD, without medical induction or social facilitation. This necessitates review of the diagnosis of MPD. Some authors have already maintained that MPD is produced by the interest of doctors and others.

Material

Sample of cases

I examined a series of descriptions of early cases which were accessible to me and which presented relevant data. All, or almost all, the prominent cases from Europe and North America have been covered, as well as some less well known. However, cases such as that of Sorgel (an early 19th-century criminal with epilepsy and automatism) or of Mesnet (a soldier who had a left parietal bullet wound and a transient right paresis) have been omitted since Myers (1903) and Sutcliffe & Jones (1962) have taken them to be subject to organic cerebral disorders. The cases of Dufay and Bellanger, summarised by Gilles de la Tourette (1887), are also not discussed, as they appear to be fugues or simple hypnotic states.

Those examined and the sources are as follows: Gmelin's report (1791) and that of Despine (1840); Reynolds as described by Mitchill (1816), Plumer (1860), Weir Mitchell (1888) and William James (1890); the cases of Skae (1845) and Mayo (1845); the cases of Azam (1876, 1887, 1892), Camuset (1882); Richet (1883); Bourru & Burot (1885); Pierre Janet (1887, 1888, 1889, 1907, 1911, 1913); Rochas (1887); Jules Janet (1888); Proust (1890); James (1890) and Hodgson (1891) who both described the Reverend Ansel Bourne; Dailey (1894); Prince (1900, 1908) on Miss Beauchamp; Sidis & Goodhart (1904) on the Reverend Thomas Hanna; Hart (1912); Cory (1919); the long article of W. F. Prince (1916) on the Fischer case; Lipton (1943); a paper and book by Goddard (1926, 1927); a book by Franz (1933); and the discussion by Lewis (1953).

Five quite recent volumes and a paper concerning five individuals have also been examined (Thigpen & Cleckley, 1957; Horton & Miller, 1972; Schreiber, 1973; Sizemore & Pittillo, 1977; Hawksworth & Schwarz, 1977; Peters & Schwartz, 1978) which give information on the emergence of the phenomenon; Allison & Schwarz (1980) described still more cases incompletely.

I reviewed this material for psychiatric conditions with which MPD might be confused, or which might promote it; and the way in which the second personality emerged. The discussion of cases occurring since 1957 is intended to be illustrative and not comprehensive.

Prominent early cases

Benjamin Rush mentioned the earliest known possible cases of MPD (Carlson, 1981). Ellenberger (1970) states that case histories of MPD began to appear in mesmerist writings and later in the medical literature only after the disappearance of the phenomena of possession, although exorcism and possession sometimes still occur (Peters & Schwarz, 1978; McKellar, 1979). Ellenberger cites Gmelin's (1791) report

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of a German woman aged 20, in Stuttgart, who was impressed by refugees from the French Revolution and their aristocratic manners. She "suddenly 'exchanged' her own personality for the manners of a French-born lady . . . speaking French permanently, and German as would a French-born woman." Sufficient context is not available to evaluate this case for its onset. French and German states alternated with loss of memory for each other. "With a motion of his hand Gmelin was easily able to make her shift from one personality to another" (Ellenberger, 1970). Despine (1840) reported a case of alternating states in an 11-year-old Swiss girl, Estelle, who had been diagnosed as having a spinal paralysis and severe pains, which ultimately responded to 'magnetism'. A comforting angel, Angeline, talked to Estelle in her 'magnetised' condition, advising support for her whims. The angel prohibited all foods that Estelle disliked and ordained that she should have anything she desired, including snow. The angel said, "Let her act according to her whims; she will not take advantage of the situation". The book provides no evidence for a second 'personality'.

The first report on Mary Reynolds describes two independent states of consciousness, the first appearing after sleep. Some of her changes followed the anticipated pattern of the mesmerisers of the day, when they produced 'somnambulism' (i.e. hypnotism). Nevertheless, one also finds embedded in the descriptions some striking material which suggests manic–depressive illness. For example, Plumer (1860) wrote as follows:

> "In her first state she was quiet and sedate, sober and pensive, almost to melancholy, with an intellect sound though rather slow in its operations, and apparently singularly destitute of the imaginative faculty. In her second state she was gay and cheerful, extravagantly fond of society, of fun, practical jokes, with a lively fancy, and a strong propensity for versification and rhyming. . . . In her natural state the strange double life which she led was the cause of great unhappiness. She looked upon it as a severe affliction from the hand of Providence, and dreaded a relapse into the opposite state, fearing that she might never recover from it and so might never again in this life know the friends of her youth, nor her parents, the guardians of her childhood. . . . In the abnormal state, though the prospect of changing into her natural state was far from being pleasant to her, yet it was for different reasons. She looked upon it as passing from a bright and joyous into a dull and stupid phase of life."

Mitchell (1888) confirmed Plumer's account with Mary's relatives, the Reverend Dr John V. Reynolds and his brother Mr William Reynolds. Using material which also appears in the earlier reports, he portrayed Mary Reynolds as having a profound sleep, after which she awakened in a state of unnatural consciousness. Her memory had fled. "All . . . that remained to her was . . . a few words". She had to be taught their significance, who were her relatives and friends, and her duties. She quickly relearned reading and writing.

> "Formerly she had been melancholy, taciturn and reserved, but now she was jocose and unrestrained. She had no fear of rattlesnakes, copperheads or bears . . . in this peculiar state Mary's parents had no control whatever over her. She was very fond of exercising her ingenuity, inventing tricks at the expense of theirs, . . . for the purpose of enjoying a laugh and causing others to join in it, at the ludicrous figure in which she never failed to make them appear."

After five weeks she reverted to her former state, which alternated with the new condition at intervals of varying length for 15 or 16 years. Once her natural disposition returned "Her melancholy was deepened by the information of what occurred". When she was cheerful her buoyancy of spirits was so great that no depression was produced; in her other state she was quiet and shy, and there were times when she manifested an unusual degree of nervousness and restlessness. When she was 35 or 36 the alternations ceased, leaving her "permanently in her second state" until she died, aged 61.

Apart from the amnesia, this case resembles bipolar affective illness. However, Mary apparently awoke with an amnesia and communication was employed to build up her knowledge of the world. During re-education the original pattern may be re-introduced or new patterns encouraged. So much must depend upon the response by others that it is unlikely that anyone waking with a hysterical amnesia would develop a 'new personality' without assistance. In fact, Reynolds kept her identity but changed her mood. Mitchell described her later phase as a gradual change "from a gay hysterical mischievous woman, fond of jests and subject to absurd beliefs or delusive convictions, to one . . . sobered down to levels of practical usefulness".

At the reading of Mitchell's paper, Dr H. C. Wood said that 'double consciousness' was about as bad a term as could be selected. He compared the case with that of a lady who suffered from melancholia and who alternated between being rather coarse and rude and thoroughly disregarding the rights of others on the one hand and suffering from the deepest religious melancholia on the other. In the same discussion, C. K. Mills said that the case resembled "insanity of double form", which we would now call manic–depressive illness (Carlson, 1984).

The case of Skae (1845) is a further striking example of such bipolar illness. The patient was a man of regular and retiring habits, and extremely temperate, who "commenced with the usual symptoms of dyspepsia" which gradually passed into "hypochondriacism" and then into a state "bordering between hypochondriasis and mental alienation". At the height, "Feelings of gloom and despondency were at the same time developed:- the most trifling errors of the past were magnified into crimes of unpardonable magnitude, and the future was contemplated with the utmost dread". He spent much time reading and incessantly turning through the Bible, sat up the greater part of every night, lay in bed during the day, and "under the influence of the bodily distress and mental despondency . . . he not infrequently spoke of drowning himself, or of throwing himself out of a window, and on several occasions begged earnestly that he might have his razors". After nine or ten years the

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symptoms, which had been aggravated somewhat on alternate days, became distinctly periodic:

> "On each alternate day, the patient is affected in the manner just described and will neither eat, sleep nor walk, but continues incessantly turning the leaves of a Bible, and complaining piteously of his misery. On the intermediate days he is comparatively speaking, quite well, enters into the domestic duties of his family, eats heartily, walks out, transacts business, assures everyone he is quite well, and appears to entertain no apprehension of a return of his complaints."

This is evidently a patient who began with depression and dependency and moved into a regular fluctuation from cheerful indifference to depression on alternate days. The case of Mayo (1845) is only described briefly but also resembles a bipolar disorder, a dull, quiet phase contrasting with one of extreme excitement.

In Europe most early cases showed only 'dual consciousness'. Authors such as James (1890) and Janet (1889, 1911) were interested in dissociative phenomena as a means to understanding the operations of the conscious mind. Independent personalities were of secondary importance initially. When they were proposed, it was often done overtly. Jules Janet (1888), the brother of Pierre, hypnotised Blanche W, a patient with hysterical symptoms at the Salpêtrière, and restored normal function. This lady appears in the famous picture reproduced by Owen (1971) and by Goetz (1987) of Charcot demonstrating hysterical dystonia. Janet says, "She willingly accepted the name Louise, which I suggested to her", but she still regarded herself as Blanche. More personalities with stronger delineation emerged only later. Greaves (1980) states that the description of multiple selves appeared in the 20th century. There are hints, however, in several famous French cases.

Azam (1876, 1887, 1892), a professor or surgery interested in hypnotism, described Felida X at the age of 47 after 32 years of observation. She had convulsions and was hysterical, and "was industrious, intelligent, and of a serious, almost sad, character" (Azam, 1876). In what was taken to be her basic condition,

> "she thinks unceasingly about her morbid state which causes solemn preoccupations, and suffers from sharp pains in several parts of the body especially the head. The symptom called hysterical nail (i.e. sharp localised pain in the head) is prominent. One is particularly impressed by her sombre manner and the lack of desire which she has to speak; she responds to questions but that is all . . . ." (Azam, 1876)

Azam describes how then almost every day without any apparent cause or any excitement, she enters her second condition. Suddenly, after a pain in the temples, she falls into a profound sleep which lasts from two to three minutes. Then she wakes, merry and laughing. She hums a tune as she goes on with the work she is engaged upon, makes jokes with those about her, and does not suffer from the neuralgic pains of her supposedly ordinary state. "In this state, which we call the second condition, Felida has a complete knowledge of the whole of her life" (Azam, 1892).

> "For the last nine or ten years the periods of the second condition have diminished in time of duration to lasting a few hours only and appearing only every 25 to 30 days. So that Felida is almost cured, and will be perfectly so at . . . the menopause."

Azam (1892) denied the diagnosis of dual personality, and explained 'doubling of consciousness' in terms of somnambulism. The correct diagnosis today might be a rapid-cycling bipolar state modified by cultural expectations.

Pierre Janet described a number of cases, particularly Leonie, Lucie, Rose, Marie, and Marceline. Leonie had been much treated previously by 'magnetisers'. Janet (1888, p. 260) writes, "the magnetizers called her Leontine during somnambulism and recognizing that they had reason to give a new name I kept it". In 1889 he was to say,

> "formerly we gave the subject different forenames . . . condition of Leonie, condition of Leontine, etc. The confusion caused by this practice was recognized. Now following Azam, we will say condition 1, condition 2, condition 3, for each subject . . ."

He then identified patients in different states according to the pattern Lucie 1, Lucie 2, Lucie 3, etc.

Leonie 1 knew only of herself; Leonie 2 (Leontine) knew of herself and of Leonie 1, of whom she said "That good woman is not myself. She is too stupid". A third Leonie emerged who knew of herself and of both the others. The early history of how Leonie 2 emerged is lost, but obviously suspect of production by her 'magnetisers'. Janet seems to have rediscovered her through automatic writing produced in response to a post-hypnotic suggestion made over two months previously. There was a letter in her normal style of Mme B (the original name of Leonie) and another one on the back of the page signed by Leontine, saying how much trouble Leonie was giving to Leontine (Janet, 1888, pp. 252–253). Leonie was hypnotised repeatedly from 1860 onwards and by Janet himself many times at least from 1885 onwards. Myers (1903) describes her as Janet's classic case of factitious secondary personalities.

Janet (1887) describes at length his practice with Lucie, a much younger girl with a history of many hysterical symptoms. In this principal description, repeated and varied somewhat two years later (Janet, 1889), he distinguishes between three phases: the original individual, a hypnotised state, and another character which emerged under automatic writing. In his 1889 volume and later editions (Janet, 1913, p. 87) he describes hypnotising Lucie and establishing this state of altered awareness, which he called Lucie 2. One day she failed to obey the hypnotic suggestion and, to augment her response, he made hypnotic passes on Lucie 2 as if she were not already hypnotised. After various changes, a new personage, Lucie 3, emerged.

The following exchange occurred with Lucie under hypnosis and through automatic writing.

"How are you?"
"I don't know."
"There must be someone there who hears me."
"Yes."
"Who is it?"
"Someone other than Lucie."

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"Ah indeed. Another person. Would you like us to give her a name?"
"No."
"Yes. It would be more convenient?"
"Alright, Adrienne."
"Very well Adrienne. Do you hear me?"
"Yes."

Janet adds: "Without a doubt I suggested the name of the personage and gave it a lot of individuality but we saw how much it develops spontaneously . . . this naming of the unconscious personage greatly facilitates the experiences" (1913, p. 318). Janet was nevertheless convinced that although these hypnotic states were often imperfect and rudimentary, they could also constitute a new existence, more complete than the normal existence of the individual. The life or vitality of a psychological system, in favourable circumstances, would constitute different personalities with various hypnotic somnambulistic states. However, the act of asking a hypnotised subject if someone else is there clearly encourages the production of an artificial entity. Janet actually also declares about these subjects (1913, p. 178), "We consider that we have been able to establish, even to produce at will, somnambulism which are completely the same as those of Felida". Binet (1891) made a telling comment about the above exchange with Lucie: "it is plain that M. Janet by christening this unconscious person, and, more still, by declaring that someone must exist in order to answer him, aided materially in the formation of a person; he himself created her by suggestion".

Rose and Marie, like Leonie and Lucie, had numerous variations under hypnosis. The exact origin of these cases and their second forms of personality is either dubious or is not described in detail in any of the original sources listed here. However, all had hysterical symptoms and multiple changes under hypnosis. Janet describes Lucie and Marie (1913, p. 131), asserting their identity. One says, "It is I Lucie but you have changed me", and Marie says, "It is still always me . . . but not at all the same thing". Janet goes on to remark that Deleuze had observed that some 'somnambulists' talk of themselves in the third person.

Janet (1907, 1911) had another case, which he called an "artificial Felida", referring to the moods of depression in both cases. Janet (1907) wrote of

> "a double personality . . . produced artificially. . . . in 1887 a young woman of 20, whose name was Marceline, entered the hospital . . . . For several months past she had not taken any food [and] had reached the last stage of emaciation."

Marceline was fed under hypnosis. After hypnosis she forgot what had happened. She could not get out of bed and had retention of urine, which hypnosis relieved without catheters. Repeated hypnosis kept her lively, cheerful, intelligent, and active by day. At night she was allowed to relapse, inert and immobile. The treatment begun by Jules Janet in 1887 was continued by his brother Pierre, for over 10 years.

Janet (1907, 1911) never gave Marceline another name. He studied differences between the two phases in which memory, mood, and behaviour alternated, but the individual was still the same person. At times Marceline fell into profound depression. Janet (1911) finally concluded "dual personality is the hysterical form of periodic depression". The strongest reason for calling Marceline an 'artificial Felida' was the induction of alternating retarded or withdrawn states, and cheerful, alert ones. We may wonder how many other cases of recurrent depression have been cast in a pattern of dissociative disorder from Mary Reynolds onwards. Certainly, a relationship between hysterical symptoms and depression has been suggested on other grounds as well (Slater, 1965; Merskey, 1979).

Felida (Azam, 1876, 1887, 1892) and Janet's cases (Janet, 1889, 1911) offer 19th-century instances where more than two such conditions emerged. In Felida a frequent state of an elevated mood alternating with the primary personality was observed, and briefly a third state in which the patient had some terror. In Leonie all three personalities had similar names, and the secondary personalities had knowledge of those revealed earlier. Lucie, Marie and Rose resemble Leonie. I suggest that there is so much evidence of active shaping of Janet's cases that it would be unjustified to accept any of them as spontaneous examples of MPD without strong positive evidence for the syndrome, which is lacking. We also see that Leonie came to Janet fully formed by 'magnetisers', the naming of individual personalities was a practice which he took from them, and there is open acknowledgement of pressure on his other subjects to develop secondary personalities. On occasion he appears to indicate this for all his cases, not only Marceline who is frankly described as an 'artificial Felida'.

Another leading French case, Louis V, described by Camuset (1882), Bourru & Burot (1885) and Myers (1886), is complicated and varied, with hysterical paralysis, mood changes, and a motive to avoid punishment. The emergence of the personality change is also not described in detail. Richet (1883) describes women with partial striking amnesias. He says of his cases however that they have lost the memory of their personality. They gave to their *moi*, forms which were different from their real forms. He sees this as a transformation of personality for which it was enough to pronounce one word with sufficient authority. He describes the activities of M, in different roles of peasant, actress, general, priest, and nun. Another patient is a general, sailor, old woman, little girl, and pastry-cook. These cases appeared to be frank examples of play acting under the command of the hypnotist rather than any form of spontaneous alternate personalities.

Similar dramatic changes were obtained by Rochas (1887), who presents a case where a change of name and role was produced by post-hypnotic suggestion. On the other hand the case of Proust (1890) was a lawyer with hysterical fugues, easily hypnotised, convicted of dishonesty, and pardoned on the grounds of automatism. None of these cases shows a valid pattern of independent personalities and Proust presents his case only as one of automatism.

Dailey (1894) described a melodramatic case with initial head injuries and clairvoyance. According to Dailey, both George M. Beard and W. A. Hammond denied the validity of his case. Janet (1907) wrote about it:

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"The history is strangely related; you feel in it . . . an exaggerated seeking after surprising and supranormal phenomena. Mollie Fancher . . . at least five persons, who have very poetical pet names: Sunbeam, Idle, Rosebud, Pearl, Ruby . . . . The complication of this case is very amusing."

Many early cases had evidence of organic disease. Among 14 cases before 1905 at least two, and possibly three, had significant evidence of brain damage while another three had evidence of epilepsy (Sutcliffe & Jones, 1962). Other patients had fugues or somnambulistic states or were hypnotised, although some of the remaining cases were said by Sutcliffe & Jones to demonstrate true MPD. An embarrassing failure to recognise an organic element appears later in a case described by Franz (1933) (see below).

Thus it appears that the leading 19th-century cases were examples of bipolar illness (Reynolds, Skae's patient, Felida), organic cerebral disorder (Myers, 1903; Sutcliffe & Jones, 1962) or hypnotic induction. The latter was sometimes overt and frequently persistent, if less obvious.

The turn of the century

The Reverend Ansel Bourne of Rhode Island (James, 1890; Hodgson, 1891) was an itinerant preacher who disappeared from home. Two weeks later a man calling himself A. J. Brown rented a small shop at Norristown, Pennsylvania. Some seven weeks subsequently he woke in a fright and asked where he was. He said that his name was Ansel Bourne; he was entirely ignorant of Norristown. Under hypnosis he recalled the lost initial two weeks, which included visits to Boston, New York, and Philadelphia, resting, reading, and looking around. Coons (1984) denies that this was a case of MPD and emphasises the misdiagnosis of many early cases.

This case seems to represent a fugue in which the patient established a new identity. Unlike most MPD cases the persistence of the role was brief and the alternate state was less happy or lively than the usual secondary and tertiary personalities which are described. Stengel (1941) noted the importance of depression in many fugue states.

The Reverend Thomas Carson Hanna was born in 1872 (Sidis & Goodhart, 1904). On 15 April 1897, he fell from his carriage and was picked up unconscious. Large doses of strychnine were administered hypodermically, and on waking the Reverend Hanna appeared to be offering to push one of his physicians. He was strong but was overcome and bound with straps. He lay quiet and the straps were removed, after which it was recognised that he had lost his speech and appeared to be in a state of "complete mental blindness". He was re-educated, like an infant. In May 1897 the observers remarked,

"No memory of his previous life spontaneously occurs to him. The time of his accident may therefore be considered as the boundary line between two distinct and separate lives of the same individual . . . . We may say *two personalities* dwell within the same individual." (my emphasis)

The Reverend Hanna was investigated through dream analysis, interview, and hypnosis. He was encouraged to establish recollections. Incidents from his past life were recalled, or reconstructed (or created). After two months the personalities were reconstituted, apparently spontaneously, in a state resembling mental stupor. No second personality is described, only the recall of primary experiences alternating with the impaired awareness of the external world associated with an amnesia, possibly organic initially, with hysterical elaboration.

The most famous case is that of Christine (Sally) Beauchamp. Prince described her first in 1900, reported her at length in 1905 in the first edition of *The Dissociation of a Personality*, and extended the description subsequently in 1908 and 1920. Before Prince's case, most examples were patients with episodes of altered consciousness in which information about the world and themselves was merely reduced, or individuals who entered into a second mood state, or condition of activity.

The birth of Sally

Prince ultimately described four different personalities in his patient. It is instructive to examine his description of "the birth of Sally" from Miss Beauchamp. He first presents the contents of a hypnotic session in which he was taxing her with not remembering material she had clearly referred to on previous occasions. He then says that he was startled to hear her, when hypnotised, speak of herself in her waking state as 'she'. He writes (the emphasis is mine):

"but now the hypnotic self, for the first time, used the pronoun 'She', in speaking of her waking self, as if of a third person; but used 'I', of herself in hypnosis. The tone, address, and manner were also very different from what they had been . . . my experience of this case entirely contradicted the view that I had held up to this time. My conviction had been growing that so-called personalities, *when developed through hypnotism*, as distinct from the spontaneous variety, were purely artificial creations, . . . in opposition to this view the personality known as B III, or Chris, which first made its appearance during hypnosis, . . . originated and persisted against my protests and in spite of my scepticism . . . asked . . . who 'she' was. The hypnotic self was unable to give a satisfactory reply.

'You are "She",' I said.

'No, I am not.'

'I say you are.'

Again a denial.

. . . I made up my mind that such an artifact should not be allowed to develop. I pursued her relentlessly in my numerous examinations, treated the idea as nonsense, and refused to accept it . . .

Finally:

'Why are you not "She"?'

'Because "she" does not know the same things that I do.'

'But you both have the same arms and legs, haven't you?'

'Yes, but arms and legs do not make us the same.'

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'Well, if you are different persons, what are your names?' . . .
[On another occasion they spoke as follows:]
'Listen: now you say you are Miss Beauchamp.'
'Yes.' . . .
'The last time we talked you said you were not Miss Beauchamp.'
'You are mistaken. I did not. I said nothing of the sort.'
'Yes, you did.'
'No.'"

McDougall (1948) observes:

> "It has been suggested that in the course of Prince's long and intimate dealings with the case, involving as it did the frequent use of hypnosis . . . he may have moulded the course of its development to a degree that cannot be determined. This possibility cannot be denied."

Perhaps Prince did not discourage multiple personality as much as he suggests. Despite his statement to the latter effect, he asked for names, and he strongly reminded the patient of another 'she'. We cannot know what would have happened had he ignored minor discussion of the patient's self in the third person.

After Morton Prince

Bernard Hart (1912) had a patient who had an angry outburst followed by a partial amnesia. He was told in psychotherapy that he was like a person who was not whole, sometimes like four-fifths of the whole individual, sometimes like one-fifth chipped off. Hart says "The 1/5th man" underwent a rapid development, and was subsequently a much more complicated person than on the occasion of his first appearance.

The more prominent cases in this period were mostly described in America. Doris Fischer (Prince, 1916) is reported in a rambling fashion. The emergence of the first personality is associated with strong hints of possession and hysterical delirium or 'sleep'. Two secondary personalities are said to have emerged at the age of three when the patient was physically ill treated. The information given is essentially retrospective as well as jumbled.

Goddard (1926, 1927) met his patient, Norma-Polly, when she was 19 and an established patient with at least two different phases of personality. Good reasons are given for emotional disturbance in this patient's life but the process of appearance of the second personality is not specified. A strong hint is offered on page 115, were it is suggested that at the age of 18 the patient had the opportunity to visit a sister, aged four, who was being very well cared for, when she was not. She would have been expected to imagine herself in her sister's place. Such legitimate wishes could have developed into the evolution of a personality with another name. However, the proof of this is lacking. Hacking (1991) has obtained evidence that Norma was admitted to a psychiatric hospital in 1923 with a diagnosis of mania, although Goddard claimed she had been cured.

One of the most interesting cases is briefly described by Cory (1919). A young woman sitting alone in the house at the piano felt as if something said to her, "take a deep breath", and the sound of singing which she had never heard before came from the same direction and frightened her. Just before the song she had shuddered and felt as if something had possession of her, she went to the kitchen to get a drink then and asked, mentally, who was it that sang, and she acquired another name. It was several weeks however before this other person learned to emerge or to submerge the original personality of the patient. This appears to have been a day-dream or wish for fulfilment of another role partly granted by the unconscious. The new person began to speak garbled Spanish, which fitted the needs of that personality. On close inspection this case looks rather like one which might have to be treated as an example of conscious fantasy. It is also not outlined in very much detail.

Misdiagnosis and overt production

The case of Franz (1933) reflects partial misdiagnosis. The patient suffered from a confusional state due to neurosyphilis and then contracted malaria, which probably halted the syphilis, or slowed it down, but left brain damage. The original physicians did not recognise the diagnosis of neurosyphilis. The patient moved to America and was examined and reported by Franz (1933) simply as a case of MPD. Before the book appeared the patient returned to England, gave evidence of a manic–depressive syndrome, was admitted to the Maudsley Hospital in London in 1931, and was shown to have positive serology for general paresis of the insane. After treatment with induced malaria, he still showed some (organic) memory disturbance (Lewis, 1953). Lewis provides a compelling argument that this patient had some organic brain change and hysterical symptoms at the time that he was diagnosed as a case of MPD. The conclusion of Sutcliffe & Jones (1962) and the organic evidence in the case of Thomas Hanna were noted above.

Sara, the case of Lipton (1943), had repeated attacks of amnesia. Lipton wrote:

> "In discussing . . . violent behaviour with the . . . staff, as well as with Sara, one was constantly saying, 'Sara changed again', or 'Sara had one of her violent spells', or some similar expression. . . . it was decided to call the patient by another name, Maud, when she appeared different . . . this was merely for convenience. . . ."

A determined effort was made to be kind and considerate to Maud. Soon two different personalities emerged. Sara was mature and intelligent, with an IQ of 128. Maud had an IQ of 43. Numerous other differences developed. Later, a third personality emerged. "She identified herself as Sara and denied the existence of any other personality as did the other two. She was dubbed Ann . . . . The failure to discover Ann in seven months of observation in the hospital, for a time even after diagnosis of dissociated personality was made, is evidence of the skill with which the various personalities 'covered up'." The question arises to what extent a similar manufacture occurs with other

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cases, albeit less obviously. Frank suggestion was remarked upon previously, with hypnosis by Pierre Janet (1889, 1911), and Jules Janet (1888), as well as the highly questionable evolution of Hart's case.

Recent cases: from Eve to Billy Milligan

Christine Costner Sizemore, called 'Eve' by Thigpen & Cleckley (1957), also provided her own version of events (Sizemore & Pittillo, 1977). She was seen for headaches as an out-patient. She seemed to be "neat, colourless, gentle, humble, not under-nourished". During one interview she spoke of a voice she heard, apparently wishing to say more and finding herself at a loss for adequate expression. The medical authors write,

> "Eve seemed momentarily dazed. Suddenly, her posture began to change. Her body slowly stiffened until she sat rigidly erect. An alien, inexplicable expression then came over her face. . . . suddenly erased into utter blankness . . . . Closing her eyes she winced . . . . A slight shudder passed over her entire body.
>
> Then the hands lightly dropped. She relaxed easily . . . . There was a quick reckless smile. In a bright, unfamiliar voice that sparkled, the woman said 'Hi there Doc!'
>
> With a soft and surprisingly intimate syllable of laughter, she crossed her legs, carelessly swirling her skirt . . . in a manner which was playful and somehow just a little provocative."

Sizemore says that after a discussion of 'hearing voices' she changed.

> "As she sat . . . eyes downcast, unable to hide her pain, she moaned softly, then slowly the head raised, straight and proud; the sparkling eyes gazed back at him sardonically.
>
> 'Hi Doc', she chirped, changing the tired droop of her body to a sensuous slouch with one almost imperceptible wiggle.
>
> She asked the doctor for a cigarette, which he gave to her hesitantly. He lit it for her and said,
>
> 'Who are *you*?'
>
> 'I'm me', she flipped.
>
> 'And what is your name?' he pursued.
>
> 'I'm Chris Costner.'
>
> 'Why are you using that name instead of Chris White?'"

Thigpen & Cleckley described their case as Eve White who altered to become Eve Black. The patient described herself as Chris White who altered to become Chris Costner. Costner was her maiden name and there were substantial marital difficulties.

Dr Thigpen witnessed a dissociative episode. The important difference between the two accounts is that Eve used her maiden name, a point not evident in *The Three Faces of Eve*. We can see denial of the marriage, for reasons well described by both doctor and patient. A different pose and set of attitudes were adopted but this might not have been another 'personality'; it was an affirmation of a previous (real) single state which the patient regretted leaving. However, the patient's account does partly support the earlier psychiatric account. Sizemore indicates that as Miss Costner, she denied having a child and defended herself by saying that her body might have had the baby but not when she was in it. In any case, once the decision was made to accept a denial of marriage as a second personality, a different pattern followed. From then on, Sizemore had repeated dissociative episodes and ultimately she described up to 22 different personalities.

Sizemore was emaciated and depressed on admission. Her childhood as described included some frightening experiences, but not childhood abuse, unlike nearly all recent cases.

'Elizabeth' (Congdon *et al*, 1961) described a spontaneous change. This came after *The Three Faces of Eve*. No report is given about inquiry into the possible knowledge she might have had concerning MPD. Since the widespread publicity about *The Three Faces of Eve* and *Sybil*, all subsequent cases are suspect of being prepared by prior information.

Horton & Miller (1972) reported 'Gloria', a very disturbed 16-year-old with varied moods, fainting turns, and somnambulism, who said one day, "Four years ago I . . . went by the name Sue", and ultimately described four different personalities. Preferring a different name probably served here as a springboard for new personalities.

Sybil (Schreiber, 1973) was 1.65 m (5 foot 5 inches) tall, and weighed 34.5 kg (79 lb) when, after repeated amnesias, she entered treatment with Dr Wilbur. Early in treatment she read many psychiatric case histories. During one session she abreacted violently, regressed in her age, changed her accent, and spoke atypically and ungrammatically. She described an incident in which a child was killed. Dr Wilbur said to her, "Who are you?" She answered, "I'm Peggy".

Peggy then admitted to living with Sybil and her mother but denied that she was the daughter of Sybil's mother. The doctor concluded that Sybil was a case of MPD.

Sybil's mother was probably psychotic, treated her appallingly and called her by different names which she preferred (e.g. 'Peggy'). Victor (1975) held that Wilbur persuaded Sybil to believe in extra personalities, but the patient's reading in the existing literature may also have contributed.

Both the last two cases had conscious awareness of the adoption of different imaginary roles. Henry Hawksworth had five personalities, also adopted consciously (Hawksworth & Schwarz, 1977). The second appeared when he was three years old and persisted for 40 years. He was abused and later suffered from marked depression, elation, and abuse of alcohol. He pretended (p. 23) that another version of himself, an imaginary playmate 'Johnny', lived inside a ventriloquist's doll. Even if he blamed 'Johnny' for his misdeeds he recognised that he himself still got punished at home and at school. Hawksworth recalls being in the playground, thinking of himself as Dana. His teacher said:

> "'Henry Hawksworth, you are to report to the principal's office immediately.'
>
> 'Yes Ma'am', said Dana, uncertain why the principal would want to see him."

He was punished for bad language, spoken by Johnny.

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In this case serious adult misbehaviour occurred, alternating with phases of sober, calm, settled, and successful work as a law-abiding citizen. The adoption of multiple personalities was conscious and grew out of childhood fantasies with an obvious motive, which are also presented as overtly conscious. There is also another difficulty. Like others in this group, the story is not always told consecutively, like a psychiatric history, but often in the screen-play, flash-back pattern.

Christina (Peters & Schwarz, 1978) was terribly abused. A brutal father killed one of her baby siblings, terrorised her mother, and raped her when she was five. She lost consciousness or recollection, and woke in an orphanage as Marie. She became an alcoholic and a drug addict, fantasised about spirits, and believed she was possessed. Her doctor claimed to exorcise her. Afterwards he introduced her to the idea of multiple personalities and she developed them. As a child she had retreated into an alternative identity. Her adult condition was taught to her.

W. S. Milligan (Keyes, 1981) committed repeated rapes. He was found not guilty by reason of insanity, that is MPD, and has been kept in a psychiatric forensic institution. In his first year of life he was in and out of hospital. His alcoholic father committed suicide. A brutal stepfather abused him physically and forced anal intercourse when he was eight or nine years old. From the age of three years and eight months he had an imaginary playmate. At one time he wanted to play with his baby sister, but his mother said he could not do so. When bored, he went to sleep and when he woke he had the identity of 'Christene', who could play with the baby. It is not clear if this was an unconscious switch. By the age of nine, he had six other imaginary identities, seemingly often conscious. Every situation called out a new role, for example Adalana, a girl who would enjoy washing dishes when it was required.

Eve and Sybil had depression, severe anorexia, and hysterical amnesias or fugues. The first appearance of a 'secondary personality' in Eve was an episode of denial of her marital relationship. We are not informed if she knew of MPD before the change. Once she became a 'case' of MPD the stage was set for 22 individual forms to emerge. Thigpen and Cleckley (Thigpen, 1984) have been reluctant to diagnose subsequent cases, but 'Eve' has been the model for hundreds more, perhaps for all the cases that followed.

Before the full adult syndrome emerged, Christina had direct instruction from her doctor about multiple personality. Elizabeth followed Eve. Sybil probably read descriptions of MPD and was persuaded by her therapist, at least in part. Hawksworth, Milligan, Sybil, Christina and Gloria, consciously used their alternate roles for emotional relief, or social advantage. Eve's case has the most convincing descriptions and yet a doubt remains. In her case it is uncertain whether there was prior knowledge of the concept of MPD. On the other hand, it does not appear to have been ruled out, there is a strong lead to another explanation, the childhood experience is not apparently typical, and the more sceptical we become about personality number 22, the more we may question the first alternate. The case of Milligan also raises doubts but its reliability has already been strongly questioned (Thigpen, 1984).

In these cases the role of a secondary personality, at any age, developed out of depression or severe emotional conflict, and as a protection from experiences which could not otherwise be tolerated. In most or all of them, spontaneous origin of anything that we should call MPD, without some prior awareness of the disorder, is either doubtful or disproven. This need not imply malingering – that is, the conscious adoption of a symptom in order to achieve a deliberate or unfair benefit, ordinarily at the expense of others or society. Here the patient, with some awareness, adopts a role which at least part of the environment favours.

Cases like that of the Reverend Ansel Bourne suggest that brief spontaneous second identities may emerge in vulnerable individuals with the help of depression and environmental stress. Secondary identities may appear in others like Gloria, Sybil or Henry Hawksworth as a result of fantasies of imaginary companions, social encouragement, or some combination of these items. However, the persistence of such discrete identities, if any, is not evident without the artefactual medical, psychological or social processes noted above.

Lastly, among case reports, Allison & Schwarz (1980) describe several patients. Their first presented fully formed. Analysis of her process suggests spontaneous developments as a child, but the origins of the adult patterns are not clear. Another patient was treated by exorcism. No example in the book, which is written for the general reader, is convincing.

Greaves (1980) notes that Christine Beauchamp (Prince's case) had four personalities; others have had 16 (Schreiber, 1973), 22 (Sizemore & Pittillo, 1977), and even 35 (Allison & Schwarz, 1980). Kluft (1982) described 60 cases in some detail, of whom only 11 had 2 personalities, 8 had 3–5 personalities, 20 had 6–10 personalities, 19 had 11–20 personalities, and 2 more than 20 personalities. Hilgard (1988) observed that such numbers "as well as those reported by several others, are bound to raise doubts about diagnoses".

Discussion

The early cases show limited development of dual consciousness. Their changes are related to fluctuations of mood, anorexia, hypnotism, overt suggestion, or organic disease. Dual personality as distinct from dual consciousness is sometimes explicitly denied (Azam, 1887).

James, Azam and Janet were concerned with somnambulism, awareness, automatic behaviour, attention, memory, dissociation, and, ultimately, recognition of the self and awareness of the self. These topics were prominent for Herbert Spencer in his book *The Principles of Psychology*, in 1855, and are described by Coupland (1892) among others. They continued into the 20th century (e.g. Myers, 1903; Stout, 1919). The discussion centred on ways to understand the operations of the mind, in quite another direction from the issue of multiple selves.

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A number of the early cases raise questions of diagnosis. Three of the most famous have a strong spontaneous streak of bipolar fluctuation or depression persisting for many years, viz. Mary Reynolds, the case of Skae, and Felida X. Others have a prominent (and generally accepted) organic contribution (e.g. Myers, 1903; Sutcliffe & Jones, 1962). The cases in the 20th century of the Reverend Thomas Hanna and Franz/Lewis' patient also had undisputed organic problems. All the cases of Pierre Janet, as well as most of the other French ones, emerged with hypnosis. Marceline was severely anorexic, like Eve and Sybil later. Alcoholism was overt in later cases (Hawksworth, Christina). Louise (Janet, 1888) and Sara (Lipton, 1943) were openly created, probably like Leonie and several others.

No case has been found here in which MPD, as now conceived, is proven to have emerged through unconscious processes without any shaping or preparation by external factors such as physicians or the media. In respect of this argument, we may have reached a situation comparable to Heisenberg's principle of uncertainty: observation of the phenomenon changes it. If this is true it means that no later case, probably since Prince, but at least since the film *The Three Faces of Eve*, can be taken to be veridical since none is likely to emerge without prior knowledge of the idea.

It is likely that MPD never occurs as a spontaneous persistent natural event in adults. The cases examined here have not shown any original conditions which are more autonomous than a fugue or a second identity promoted by overt fantasies or conscious awareness. The most that may be expected without iatrogenesis is that an overt inclination for another role could cause the adoption of different conscious patterns of life, as in Cory's (1919) case, or perhaps the case of Horton and Miller. Without reinforcement, such secondary changes would ordinarily be expected to vanish.

Suggestion, social encouragement, preparation by expectation, and the reward of attention can produce and sustain a second personality. Admittedly, if only those physicians who expect the disorder can see it, those who do not believe in it cannot see it. However, like others, I was willing to entertain its existence and never found it myself before the dramatic rise in reported cases or since. Meanwhile, it is not necessary to treat patients who have had terrible childhoods and who have conversion symptoms, by developing in them additional beliefs in fresh personalities. Enthusiasm for the phenomenon is a means of increasing it.

We should consider how patients, and doctors, come to believe in MPD or to present the popular pattern. Four suggestions are appropriate to explain the way in which MPD is created. The first is the misinterpretation of organic or bipolar illness. The second is the conscious development of fantasies as a solution to emotional problems. The third is the development of hysterical amnesia, followed by retraining. The fourth is creation by implicit demand under hypnosis or repeated interviews. Retraining may arise in a purely dissociative amnesia, or one which is triggered by a head injury or depression but followed by hysterical patterns of memory loss. This learning effect is evident in Mary Reynolds. Mitchell reported:

> "The first lesson in her education was to teach by what ties she was bound to those by whom she was surrounded, and the duties devolving upon her accordingly. After a while some striking mood fluctuations were observed between depressed and elated, sad and retiring, or outgoing and over-confident."

Two personalities were not evident here, only two mood states. The natural effort to retrain the individual is described. The same natural effort comes out very clearly in the case of the Reverend Hanna (Sidis & Goodhart, 1904). One can imagine the consequences if this patient was in touch with someone who wanted to suggest that he might have thought that he had another mood characterised, say, by the name William. The potential for creating a new story would have been strong.

Miss Beauchamp is but another example of the fourth scenario. Prince first describes verbatim a gentle argument with his patient, under hypnosis, about what she could recall and what not. As he attributed the power of recollection to her, she presumably began to distance herself, under hypnosis, from that power and role. Ultimately, in one of her sessions under hypnosis, she used the word 'she' for herself at another time, and Prince pounced upon it. Despite his conviction that other selves appearing under hypnosis were produced by suggestion, he explored the question as to 'who' she was and then said 'you are she'. Despite her denial, he persisted with his assertion and went on, in due course, to ask her for the name of the other personality and later to remind her of 'she'. Today patients are better trained. Spanos *et al* (1986) obtained telling experimental evidence that procedures employed routinely to diagnose MPD encourage and legitimate enactments of the syndrome.

The change which occurred in Eve, as she describes it, is less impressive in a significant particular than the way in which it was described by Thigpen & Cleckley. If she did indeed principally deny her married status, choosing her maiden name once

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more, and secondarily defended her decision by denying associated items, the creation of the secondary personality was not a complete transformation. The development of the condition in some of the other cases in childhood is a kind of conscious make-believe, by necessity, and may be carried through with insight into adult life. Again, this does not amount to spontaneous, functioning alternate personalities who should be granted a life of their own for pragmatic, legal, or therapeutic purposes.

A relevant human mechanism appears in patients with paralysed limbs, or dysfunction of a part. A patient with hemi-ballismus, unable to control the erratic and violent movements of her left arm, described it separately as 'George'. The tendency to distance oneself from an unpleasant phenomenon is common and easy to adopt. MPD offers a mode of separating, splitting, and isolating particular subjective problems. However, the evidence so far implies that it requires assistance.

Proponents of the diagnosis of MPD point to the high frequency of sexual abuse in the histories of sufferers. In Canada, Ross *et al* (1990) found that 90% of 102 patients were so affected, while a national survey (Committee on Sexual Offences Against Children and Youth, 1984) indicated some sexual abuse by touching or attempted assault in 45.6% of females. This includes incidents of exposure or threatened abuse. Sexual abuse in childhood is not specific to a particular diagnosis. Walker *et al* (1988) reported that 64% of patients with chronic pelvic pain had a history of sexual abuse, whereas 23% of a control group had comparable experiences; many patients with pelvic pain also had symptoms of a type associated with depressive and somatic complaints. The frequency of childhood deprivation and other abuse in current patients with symptoms related to hysteria has been recognised for some time in discussions of hospital addiction and simulated illness (Merskey, 1979, p. 66). As investigators have tended to emphasise sexual abuse as a criterion for the diagnosis of MPD, it is hardly surprising that the phenomenon has increased in their sample, but the definition of the diagnosis in terms of sexual abuse cannot serve as a proof of the independent existence of the condition.

More recently, larger series of cases have been published and the journal *Dissociation* (no. 2, vol. 2, June 1989) has dealt specifically with the question of iatrogenesis. Several arguments are offered to deny the occurrence, or importance, of iatrogenesis. Among them, Ross *et al* (1989) claim that iatrogenic production of MPD by specialists in dissociation has not been reported in the literature. The analysis here of the most prominent cases shows otherwise. The same authors also suggest that because they have found no important demographic differences between the MPD patients of psychiatrists with many cases and psychiatrists with few cases, this means that those with many cases are not producing them differentially. This argument is not a proof of validity, only consistency of selection. Likewise, reliability of diagnosis (Ross, 1989) is not proof of validity. Kluft (1989) mentions the worsening of MPD by 'inept' therapy. Yet the authors of the relevant section of DSM-III-R allow up to 100 alternate personalities in a case, and Kluft (1982) has himself reported 19 patients with 11-30 personalities and 2 with more than 30 personalities.

Recent cases are not appropriate subject matter to explore the question of suggestion, since they have all been open to it in developed countries. Some cases recently reported from India also indicate the influence of the cinema in producing rather facile fugue states (Adityanjee *et al*, 1989). Instead, we should require that early cases, and any late cases that might be thought to have escaped the pervasive influence of the media, or iatrogenesis, should show spontaneous origin without any reasonable doubt. The more recent cases of note indicate the common, rather journalistic patterns of the supposed disorder.

It is always open of course to any particular investigator to say, "My patient had no training, arose naturally, and was not prepared by me". Fortunately, or otherwise, that position has been undermined by widespread knowledge of the concept. If the case were to be proved, it should have been done with Eve at the latest, and it was not. The concept of MPD should be seen now as, at best, a by-way in the history of ideas.

Ill-effects of the diagnosis

Many of the patients have had awful experiences with an extensive history of child abuse, which needs attention and treatment, but the diagnosis of MPD may not give the best treatment.

The diagnosis of MPD need not exclude other diagnoses, but it is likely to distract attention away from them. Alcoholism or depression may be better treated by directing attention to problems with drink or using non-addictive medication. The diagnosis of MPD (or production of it) may hinder the most appropriate action and damage treatment. Chodoff (1987) writes that in two cases demonstrated on videotape, he was struck by the bolstering of defences – with a stultifying effect on psycho-therapeutic progess – exerted by concentration on the characteristics of the individual personalities rather than the patient's underlying conflicts. Whether the

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patient needs management of social relationships, the resolution of conflicts in psychotherapy, the recognition of physical illness, or the prescription of medication, the process of treatment will not be helped by extraneous exciting diagnoses.

Another ill effect also exists. The value and good sense of psychiatry become suspect as wonders multiply.

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