

Resolved: Multiple Personality Disorder Is an Individually and Socially Created Artifact

AFFIRMATIVE: PAUL R. McHUGH, M.D.

Where's hysteria now that we need it? With *DSM-IV*, psychiatrists have developed a common language and a common approach to diagnosis. But in the process of operationalizing diagnoses, we may have lost some concepts about patient behavior. The term "hysteria" disappeared when *DSM-III* was published; without it, psychiatrists have been deprived of a scientific concept essential to the development of new ideas: the null hypothesis. This loss hits home with the epidemic of multiple personality disorder (MPD).

The work of Talcott Parsons (1964), David Mechanic (1978), and Isidore Pilowsky (1969) taught psychiatrists to appreciate that phenomena such as hysterical paralyses, blindness, and pseudoseizures were actually behaviors with a goal: achieving the "sick role." Inspired by Parsons, Mechanic and Pilowsky used the term "abnormal illness behavior" in lieu of hysteria. Their approach eliminated the stigma of malingering that had been implied in hysteria and indicated that patients could take on such behavior without fraudulent intent. They were describing an old reality of medical experience.

Some people—experiencing emotional distress in the face of a variety of life circumstances and conflicts—complain to doctors about physical or psychological symptoms that they claim are signs of illness. Sometimes they display gross impairments of movement or consciousness; sometimes the features are subtle and changing. These complaints prompt doctors to launch investigations in laboratories, to conduct elaborate and sometimes dangerous studies of the brain or body, and

to consult with experts, who examine the patient for esoteric disease. As the investigation proceeds, the patient may become still more persuaded that an illness is at work and begin to model the signs of disorder on the subtle suggestions of the physician's inquiry. For example, a patient with complaints of occasional lapses in alertness might—in the course of investigations that include visits to the epilepsy clinic and to the EEG laboratory for sleep studies, photic stimulation, and nasopharyngeal leads—gradually develop the frenzied thrashing movements of the limbs that require the protective attention of several nurses and hospital aides.

Eventually, with the patient no better and the investigations proving fruitless, a psychiatric consultant alert to the concept of hysteria and its contemporary link to the "sick role" might recognize that the patient's disorder is not an epileptic but a behavioral one. The patient is displaying movements that attract medical attention and provide the privileges of patienthood.

Talcott Parsons, the Harvard sociologist, pointed out in the 1950s that medicine was an organized component of our society intended to aid, through professional knowledge, the sick and the impaired. To accomplish this, certain individuals—physicians—are licensed by society to decide not only how to manage the sick, but to choose and distinguish the sick from other impaired people. Such an identification can provide these "sick" individuals with certain social privileges, i.e., rest, freedom from employment, and support from others during the reign of the condition. The person given the appellation "sick" by the social spokesman—the physician—was assumed by the society to respond to these privileges with other actions, i.e., cooperating with the intrusions of investigators of the illness and making every effort at rehabilitation so as to return to health. The hidden assumption is that the burdens and pains of illness act to drive the patient

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Dr. McHugh is Director of Psychiatry, Johns Hopkins University, School of Medicine, Baltimore, MD. Dr. Putnam is Chief, Unit on Dissociative Disorders, Laboratory of Developmental Psychology, National Institute of Mental Health, Bethesda, MD.

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toward these cooperative actions with the physicians and thus to be happy to relinquish the few small pleasures that can be found in being treated as a victim of sickness.

However, because there are advantages to the sick role, there are some situations in which a person might seek this role without a "ticket of admission," a disease. This is hardly a remarkable idea as almost anyone has noticed the temptation to "call in sick" when troubles are afoot. But in some patients—those with emotional conflicts, weakened self-criticism, and high suggestibility—this temptation can be transformed, usually with some prompting, into the conviction that they are infirm. This kind of patient may, in fact, use more and more information from the medical profession's activities to amplify the expression of the infirmity.

Psychiatrists have known about these matters of social and psychological dynamics for more than 100 years. They were brought vividly to attention by the distinguished pupil of Jean-Martin Charcot, Joseph Babinski (he of the plantar response). Like Sigmund Freud and Pierre Janet, Babinski had observed Charcot manage patients with, what Charcot called, "hysteroepilepsy." But Babinski was convinced that hysteroepilepsy was not a new disorder. He believed that the women at Charcot's clinic were being persuaded—and not so subtly—to take on the features of epilepsy by the interest Charcot and his assistants expressed (Babinski and Froment, 1918). Babinski also believed that these women were vulnerable to this persuasion because of distressing states of mind provoked in their life circumstances and their roles as intriguing patients and the subject of attention from many distinguished physicians who offered them a haven of care.

Babinski was bringing the null hypothesis to Charcot and with it, not a rejection of these women as legitimate victims of some problem, but an appreciation that behaving as if epileptic obscured reality and made helping their actual problem difficult. Babinski wrote that just as hysteroepilepsy rested on persuasion, so a form of counterpersuasion could correct it. He demonstrated that these patients improved when they were taken from the wards and clinics where other afflicted women—epileptic and pseudoepileptic—were housed and when the attention of the staff was turned away from their seizures and onto their lives. These measures—*isolation and countersuggestion*—had the advantage of limiting the rewards for the behavior and

of prompting a search for and treatment of the troubles in the personal life.

All this became embedded in the concept of hysteria and needs to be reapplied in the understanding of MPD. The patients I have seen have been referred to the Johns Hopkins Health System because elsewhere they have become stuck in the process of therapy. The histories are similar. They were mostly women who in the course of some distress sought psychiatric assistance. In the course of this assistance—and often early in the process—a therapist offered them a fairly crude suggestion that they might harbor some "alter" personalities. As an example of the crudity of the suggestions to the patient, I offer this published direction of how to both make the diagnosis and elicit "alters":

The *sine qua non* of MPD is a second personality who at some time comes out and takes executive control of the patient's behavior. It may happen that an alter personality will reveal itself to you during this [assessment] process, but more likely it will not. So you may have to elicit an alter personality. . . . To begin the process of eliciting an alter, you can begin by indirect questioning such as, "Have you ever felt like another part of you does things that you can't control?" If she gives positive or ambiguous responses, ask for specific examples. You are trying to develop a picture of what the alter personality is like. . . . At this point, you might ask the host personality, "Does this set of feelings have a name?" Occasionally you will get a name. Often the host personality will not know. You can then focus on a particular event or set of behaviors and follow up on those. For instance, you can ask, "Can I talk to the part of you who is taking those long drives to the country?" (Buie, 1992, p. 3).

Once the patient permits the therapist to "talk to the part . . . who is taking those long drives," the patient is committed to having MPD and is forced to act in ways consistent with this role. The patient is then placed into care on units or in services—often titled "the dissociative service"—at the institution. She meets other patients with the same compliant responses to therapists' suggestions. She and the staff begin a continuous search for other "alters." With the discovery of the first "alter," the barrier of self-criticism and self-observation is breached. No obstacles to invention remain.

Countless numbers of personalities emerge over time. What began as two or three may develop to 99 or 100. The distressing symptoms continue as long as therapeutic attention is focused on finding more alters and sustaining the view that the problems relate to an "intriguing capacity" to dissociate or fractionate the self.

At Johns Hopkins, we see patients in whom MPD has been diagnosed because symptoms of depression have continued despite therapy elsewhere. Our referrals have been few and our experience, therefore, is only now building, probably because our views—that MPD may be a therapist-induced artifact—have only recently become generally known in our community (McHugh, 1995). We seem to challenge the widely accepted view and to “turn back the clock.” The referrals that come to us often arrive with obstacles to our therapeutic plans. Patients and their referring therapists often wish to stay in regular contact (two to three times weekly) and to continue their work on MPD. At the same time, we at Hopkins are expected to treat the depression or some other supposed “side issue.” We, however, following the isolation and countersuggestion approach, try to bring about, at least temporarily, a separation of the patient from the staff and the support groups that sustain the focus on “alters.” We refuse to talk to “alters” but rather encourage our patients to review their present difficulties, thus applying the concept of “abnormal illness behavior” to their condition.

The advocates for MPD are in the same position as Charcot was when Babinski offered his proposal of the null hypothesis. As in any scientific discussion, it is not the responsibility of the proposers of the null hypothesis to prove its likelihood. That hypothesis simply claims that nothing special has been discovered. I claim the same in this debate. The investigators proposing a new entity must demonstrate that the null hypothesis should be rejected.

In most of the discussions by champions of MPD just the opposite occurs. Not only is the null hypothesis discarded without any compelling reason, but nonrelevant information is presented to justify a uniqueness to MPD. Perhaps the most common proposal is that MPD must exist in the way proposed because it is included in *DSM-IV* and operational criteria are available to make the diagnosis. This is a misunderstanding

of *DSM-IV*. It provides a way in which a diagnosis can be reliably applied to a patient, but it does not in any way validate the existence of the condition or negate a null hypothesis about it.

Charcot had quite reliable ways of diagnosing hyster-oepilepsy. It just did not exist as he thought it did, but rather it was a behavior seeking the sick role. It is my opinion that MPD is another behavioral disorder—a socially created artifact—in distressed people who are looking for help. The diagnosis and subsequent procedures for exploring MPD give them a coherent posture toward themselves and others as a particular kind of patient: “sick” certainly, “victim” possibly. This posture, if sustained, will obscure the real problems in their lives and render psychotherapy long, costly, and pointless. If the customary treatments of hysteria are provided, then we can expect that the multiple personality behaviors will be abandoned and proper rehabilitative attention can be given to the patient.

Hysteria as a concept has been neglected in *DSM-III* and *DSM-IV*, but it offers just what it has always offered: a challenge to proposals of new entities in psychiatry. Some diagnoses survive and others do not. MPD has run away with itself, and its proponents must now deal with this challenge. Charcot took such a challenge from his student. Everyone learned in the process.

REFERENCES

- Babinski J, Froment J (1918), *Hysteria or Pithiatism and Reflex Nervous Disorders in the Neurology of War*. Rolleston JD, trans; Buzzard EF, ed. London: University of London Press
- Buie SE (1992), Introduction to the diagnosis of multiple personality disorder. *Grand Rounds Rev* (4):1-3
- McHugh PR (1995), Witches, multiple personalities, and other psychiatric artifacts. *Nature Med* 1:110-114
- Mechanic D (1978), Effects of psychological distress on perceptions of physical health and use of medical and psychiatric facilities. *J Hum Stress* 4:26-32
- Parsons T (1964), *Social Structure and Personality*. New York: Free Press
- Pilowsky I (1969), Abnormal illness behaviour. *Br J Med Psychol* 42:347-351

NEGATIVE: FRANK W. PUTNAM, M.D.

For more than a century, the existence of multiple personality disorder (MPD) has provoked heated debate. That both the diagnosis and the controversy are still with us says something about the resiliency of both sides of the question. The similarities between the charges leveled in the current debate and those in the historical record suggest that things, unfortunately, have not changed very much in 100 years. It is unlikely that this exchange will resolve the matter, but perhaps we can move the question along to a higher level. The criticisms leveled at MPD are not credible when examined in the light of what we know about the etiologies of mental illness. Debate can be advanced by critiquing the validity of MPD in the same manner in which the validity of other psychiatric diagnoses are assessed.

What are the criticisms of MPD? There are three basic criticisms made against this diagnosis. The first is that MPD is an iatrogenic disorder produced in patients by their psychiatrists. The second is that MPD is produced by its portrayal in the popular media. The third is that the numbers of MPD cases are increasing exponentially. The first and second charges are often lumped together and viewed as being responsible for the third.

The first accusation is historically the oldest and the most serious because it alleges therapeutic misconduct of the gravest nature. The psychiatrist's fascination with the patient's symptoms supposedly reinforces the behavior and produces the syndrome. A variation of this accusation charges that the condition is produced by the improper use of hypnosis. In either instance, the fact is that there are no cases reported in which the full clinical syndrome of MPD was induced either by fascination or by hypnosis. Experiments by Nicholas Spanos are sometimes cited as examples of the creation of MPD by role-playing students (Spanos, 1986). The reader is invited to compare the verbal responses of undergraduates responding to a staged situation with the psychiatric symptoms of MPD patients reported in the clinical literature. Two clinical studies examined the effects of using hypnosis on the symptoms and behaviors of MPD patients (Putnam et al., 1986; Ross, 1989). There were no significant differences between MPD cases diagnosed and treated with or without

hypnosis. Since MPD appears in many patients with no history of hypnotic interventions, the misuse of hypnosis apparently is not responsible for the syndrome.

The second allegation, that MPD is induced by media portrayals, ignores extensive research on the effects of the media on behavior. More than 30 years of research on the relation of television viewing to violence informs us of just how difficult it is to find clear-cut effects produced by exposure to specific media imagery. Certainly there are media effects, but these effects are not simple and direct identifications. Rather they are indirect, cumulative, and heavily confounded by individual and situational variables (Friedlander, 1993). The depiction of violence in the media is vastly more common (perhaps it is even the norm for movies and television) than the portrayal of MPD. Yet, the critics of MPD would have us believe that the minuscule percentage of media time devoted to MPD is directly responsible for the increase in diagnosed cases. This would be an extraordinarily specific and powerful effect—far, far beyond anything found by the thousands of studies on violence conducted by media researchers.

The first and second accusations beg an important question. Why this disorder? If these individuals are so suggestible, why don't they develop other disorders? Why should suggestion effects be unique to MPD? Psychiatrists inquire about and exhibit interest in other symptoms. We do not believe that asking about hallucinations produces them in a patient. Why should asking about the existence of "other parts" of the self produce alter personalities? What is so *magical* about this question? With respect to media portrayals of mental illness, a random channel-walk through the soap opera and talk show circuits will convince one that many other symptoms and disorders fill the airwaves. Eating disorders, obsessive-compulsive disorder, bipolar illness, assorted phobias, sexual dysfunctions, autism, chronic fatigue syndrome, etc., etc., are discussed in graphic detail and glamorized after their own fashion. Why don't suggestible individuals identify with these conditions? Truly, if there is such a high degree of suggestive specificity to MPD, it is worthy of intensive investigation.

The third accusation, that cases of MPD are increasing "exponentially" or "logarithmically," shows little

understanding of basic mathematics. Critics often cite inflated numbers of cases without any support for their figures. I have plotted the numbers of published cases year by year, and while it is true that they have increased significantly compared to prior decades, the rise in the slope is not nearly as dramatic as the critics' hyperbole suggests. Over the same period, other disorders, e.g., Lyme disease, obsessive-compulsive disorder, and chronic fatigue syndrome, have shown equal or faster rises in the numbers of published cases. This reflects a basic process in medicine associated with the compilation and dissemination of syndromal profiles. When symptoms that were once viewed as unrelated are organized into a coherent syndromal presentation and that information is widely disseminated, physicians begin to identify the condition more frequently. The rapid rise in the number of cases of "battered child syndrome" following the classic paper by Kempe and his colleagues is a very relevant example of this process in action. A related criticism is that a few clinicians are responsible for most of the diagnosed MPD cases. Again, a review of the MPD literature demonstrates a healthy diversity of authorship comparable with that found for other conditions.

The crucial question raised by this debate is: How should the validity of a psychiatric diagnosis be judged? Considerable thought has gone into this question. (For a more complete discussion, see *The Validity of Psychiatric Diagnosis* by Robins and Barrett, 1989.) Many psychiatrists endorse the model of diagnostic validity put forth by Robins and Guze in 1970 and subsequently amplified by others (Robins and Barrett, 1989). This model requires that psychiatric diagnoses satisfy aspects of three basic forms of validity: content validity, criterion-related validity, and construct validity. Content validity is probably the most fundamental form of validity for psychiatric diagnosis. It requires that the diagnostician be able to give a specific and detailed clinical description of the disorder. Criterion-related validity requires that laboratory tests, e.g., chemical, physiological, radiological, or reliable psychological tests, are consistent with the defined clinical picture. Construct validity requires that the disorder be delimited from other disorders (discriminant validity).

The clinical phenomenology of MPD has been delineated and repeatedly replicated in a series of studies of more than 1,000 cases. A review of the best of these studies demonstrates striking similarities in the

symptoms of MPD patients across different sites and investigational methodologies (Coons et al., 1988, Putnam et al., 1986; Ross et al., 1990). They should convince the interested reader that a specific, unique, and reproducible clinical syndrome is being described. A small but growing body of literature on childhood and adolescent MPD links the adult syndrome with childhood precursors, establishing a developmental continuity of symptoms and pathology (Dell and Eisenhower, 1990; Hornstein and Putnam, 1992). The well-delineated, well-replicated set of dissociative symptoms that constitute the core clinical syndrome of MPD satisfies the requirements for content validity.

MPD and its core pathological process, dissociation, can be detected and measured by reliable and valid structured interviews and scales (Carlson et al., 1993; Steinberg et al., 1991). Published data on validity compare very favorably with accepted psychological instruments and satisfy the reliability requirement imposed by Robins and Guze for the inclusion of psychological tests as measures of criterion validity. These instruments have been translated into other languages and proven to discriminate MPD in other cultures. Discriminant validity studies have been conducted for the Dissociative Experiences Scale and the Structured Clinical Interview for *DSM-III-R*-Dissociative Module, both of which show good receiver operating characteristic curves, a standard method for evaluating the validity of a diagnostic test (Carlson et al., 1993; Steinberg et al., 1991). MPD is well discriminated from other disorders by reliable and valid tests and thus has good criterion-related and construct validities.

Multiple personality disorder has been with us from the beginnings of psychiatry (Ellenberger, 1970). At present we conceptualize this condition as a complex form of posttraumatic dissociative disorder, highly associated with a history of severe trauma usually beginning at an early age. I believe that research demonstrates that the diagnosis of MPD meets the standards of content validity, criterion-related validity, and construct validity considered necessary for the validity of a psychiatric diagnosis. The simplistic argument that MPD is individually and socially caused "hysteria" evades the much more important question of what is the best approach to helping these patients. Denying its existence or blaming psychiatrists and television for MPD patients' symptoms is not constructive. It is important to move beyond debate about the existence

of the condition to more serious discussions of therapeutic issues.

REFERENCES

- Carlson EB, Putnam FW, Ross CA et al. (1993), Validity of the Dissociative Experiences Scale in screening for multiple personality disorder: a multicenter study. *Am J Psychiatry* 150:1030–1036
- Coons PM, Bowman ES, Milstein V (1988), Multiple personality disorder: a clinical investigation of 50 cases. *J Nerv Ment Dis* 176:519–527
- Dell PF, Eisenhower JW (1990), Adolescent multiple personality disorder. *J Am Acad Child Adolesc Psychiatry* 29:359–366
- Ellenberger HF (1970), *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*. New York: Basic Books
- Friedlander BZ (1993), Community violence, children's development, and mass media: in pursuit of new insights, new goals and new strategies. In: *Children and Violence*, Reiss D, Richters JE, Radke-Yarrow M, Scharff D, eds. New York: Guilford Press, pp 66–81
- Hornstein NL, Putnam FW (1992), Clinical phenomenology of child and adolescent dissociative disorders. *J Am Acad Child Adolesc Psychiatry* 31:1077–1085
- Putnam FW, Guroff JJ, Silberman EK, Barban L, Post RM (1986), The clinical phenomenology of multiple personality disorder: review of 100 recent cases. *J Clin Psychiatry* 47:285–293
- Robins LE, Barrett JE, ed. (1989), *The Validity of Psychiatric Diagnosis*. New York: Raven Press
- Ross CA (1989), Effects of hypnosis on the features of multiple personality disorder. *Am J Clin Hypn* 32:99–106
- Ross CA, Miller SD, Bjornson L, Reagor P, Fraser G, Anderson G (1990), Structured interview data on 102 cases of multiple personality disorder from four centers. *Am J Psychiatry* 147:596–601
- Spanos NP (1986), Hypnosis, nonvolitional responding, and multiple personality: a social psychological perspective. *Prog Exp Pers Res* 14:1–62
- Steinberg M., Rounsaville B, Cicchetti D (1991), Detection of dissociative disorders in psychiatric patients by a screening instrument and a structured diagnostic interview. *Am J Psychiatry* 149:1050–1054.

AFFIRMATIVE REBUTTAL: MCHUGH

Dr. Putnam makes two claims: (1) that MPD is validated and (2) that a treatment program that rejects that claim will be incoherent.

To his first claim, the point of contention is not whether patients exist with a set of complaints that are internally consistent and match the criteria for MPD published in *DSM-IV*. The issue is whether this collection of complaints and behaviors represents a natural product of mental life or a socially constructed artifact generated in the interaction between patient and therapist. By an artifact I mean something forged by an artisan rather than by nature. For example, an arrowhead differs from a glacially scoured triangular stone by being the product of the hand of a human being.

All examples of MPD that I have seen give evidence of the “hand of an artisan” both in the way they emerged during therapy and the features they presented. Since MPD exists in the same way that any artifact exists, tests for content validity and criterion validity are satisfied as they represent assessments of the elements of the artifact and say nothing about its nature.

Dr. Putnam knows that construct validation is a task that is never “done” but depends on the construct surviving repeated challenges to its nature. Behavioral artifacts such as MPD succumb to the challenges that the concepts of the sick role and hysteria provide. These are the counterconstructs that I am proposing here, that are seldom addressed, and that Dr. Putnam

would dismiss as “simplistic.” I would say that his lists of validating methods are more smoke than substance when their application to this issue is carefully appraised.

To his second claim, I agree that an important question—perhaps, though, not a “more important question”—is how to help these patients. Rational treatment depends on the nature of the condition from which the patient suffers. A psychological artifact is not treated in the same way as a natural psychological condition, such as depression, grief, or demoralization. It has to be removed, not cured. In fact, the treatment of the artifact, MPD, has two aspects: First, attention to its peculiar features should cease. Stop talking to alters, naming alters, eliciting alters, charting alters, wiggling fingers at patients, and keeping patients with these behaviors together on “dissociative units.” Second, turn one's clinical attention toward the contemporary distress of the patient and its likely origin in either life conflicts or particular mental disorders. Isolation from suggestive influences, counterattention to other concerns, treatment of any underlying conditions, and social/familial rehabilitation constitute the proper and long-established sequences of treatment of medical and psychiatric artifacts in general and MPD in particular. In our hands this program leads quickly to the abandonment of MPD and progress toward overall recovery that ultimately depends on the actual condition of the patient. This treatment program is not an interminable

process, a fact worth noting as another feature validating MPD as a psychological artifact. If treated as though it were a natural mental condition, an artifact will

consume months to years of therapy, sustaining behavioral invalidism. Demystify it and it disappears.

NEGATIVE REBUTTAL: PUTNAM

Dr. McHugh's plaintive question, "Where's hysteria now that we need it?" speaks volumes about the failure of our reductionistic diagnostic system to adequately conceptualize these complex patients. The short answer is that hysteria rapidly became more of an epithet than a diagnosis and the construct was ultimately dismembered by the *DSM* into the diagnoses of borderline personality disorder; the various somatoform disorders, particularly conversion and somatization disorders; and, of course, multiple personality disorder. What we now know about this group of patients is that numerous studies show that they have significantly higher rates of childhood trauma than psychiatric patients in general or nonclinical samples. A century ago, Briquet commented on the crucial role of childhood trauma in his classic treatise on hysteria (Loewenstein, 1990).

Multiple personality disorder is not a "sick role" enacted to reduce life stress. It is a complex, childhood-onset, posttraumatic dissociative disorder. A review of the clinical literature demonstrates that, as a group, MPD patients do not require the diagnosis of MPD as a "ticket of admission" to the sick role. In fact, they typically average more than 6 years of psychiatric and medical care under other diagnoses before the diagnosis of MPD. Their unintegrated, multiple representations of self, manifest in the form of alter personalities, are an extreme example of a range of disturbances of "self" found in many victims of childhood maltreatment (Cole and Putnam, 1992).

Dr. McHugh sets up the straw man argument that MPD is iatrogenic hysteria induced by asking about alter personalities. He then attempts to duck the need to back his argument with actual data by speciously labeling it the "null" hypothesis. There are no scientific data that Dr. McHugh can cite that demonstrate that the full clinical syndrome of MPD can be induced by asking about the existence of an alter personality. If Dr. McHugh really believed that MPD is created de novo by asking a certain question, then he is obligated

to put forth supporting scientific data in the same fashion demanded of all other scientific hypotheses. Published research has repeatedly tested the MPD construct against many forms of the null hypothesis and found that these patients are significantly different, both quantitatively and qualitatively, on standardized psychological measures, structure diagnostic interviews, clinical phenomenology, studies of central and autonomic nervous system activity, and studies of memory and cognition. As I outline above, MPD fulfills the standards of diagnostic validity applied to other psychiatric diagnoses.

I believe that the critical question is not whether these patients have "hysteria" or MPD, but what can we do to alleviate their distress and to help them become more functional? Whatever one wishes to call them, there still exist a substantial number of patients with complex posttraumatic disorders associated with histories of childhood trauma. These patients have a range of disturbances in self-representations, problems with modulation of affect, elevated levels of pathological dissociation, anxiety, somatization, and high rates of suicide. The modern diagnostic construct of MPD is associated with a specific treatment model. The real question is: Is this model more or less efficacious than the treatment model proposed by critics of MPD? This is the question that should be the focus of future debate and, more importantly, clinical outcome research.

REFERENCES

- Cole PM, Putnam FW (1992), Effects of incest on self and social functioning: a developmental psychopathology perspective. *J Consult Clin Psychology* 60:174-184
- Loewenstein RJ (1990), Somatoform disorders in victims of incest and child abuse. In: *Incest-Related Syndromes of Adult Psychopathology*, Klufit RP, ed. Washington, DC: American Psychiatric Press, pp 75-112

The debaters in this section were asked to respond to the resolution from the respective viewpoints; the opinions they express may not necessarily reflect their true positions nor do they reflect the opinion of the Journal. Readers are encouraged to submit their comments about these issues as Letters to the Editor.