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Psychologists' Skepticism and Knowledge about Dissociative Identity Disorders in Adolescents

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Philadelphia College of Osteopathic Medicine

Department of Psychology

PSYCHOLOGISTS' SKEPTICISM AND KNOWLEDGE ABOUT DISSOCIATIVE
IDENTITY DISORDER IN ADOLESCENTS

By Nancy E. Madden

Submitted in Partial Fulfillment
of the Requirements for the Degree of
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DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the dissertation presented to us by Nancy E. Madden on the 9th day of September 2003, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is accepted in both scholarship and literary quality.

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Dedication Acknowledgements

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Abstract

Professional skepticism about DID and lack of knowledge about DID has been documented in the adult literature on dissociative pathology (Hayes and Mitchell, 1994). Although 100% of adult DID cases are thought to have originated in childhood as sequelae of trauma, to date no studies about professional skepticism of and knowledge about DID have been done with psychologists who specialize in assessing children and adolescents. This study was designed to investigate the beliefs about DID and knowledge of DID that has been garnered by psychologists who specialize in assessing and treating adolescents. This study consisted of a convenience sample of 34 participants recruited from the American Psychological Association's Division 53 and from participants surveyed via the Internet. This research replicates the study done by Hayes and Mitchell (1994) utilizing the Skepticism and Knowledge Scale designed by them. The abysmal response rate of 2.7% allowed for descriptive analysis but reduced power in calculating correlations between variables. Results indicated an inverse correlation between the Skepticism and the Knowledge variables. Unlike similar studies in the adult literature about dissociative pathology, participants lacked skepticism about DID and were knowledgeable about DID. Yet only 17.6% of the sample accurately diagnosed the DID vignette. The findings of this study reinforce other research findings (Putnam, 1991) that

DID, the paradigmatic Dissociative Disorder, is seldom diagnosed in childhood and adolescence. The limitations of this study suggest that findings should be regarded as exploratory rather than conclusive as those who chose not to participate may have done so because of extreme skepticism as well as lack of knowledge about DID.

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Psychologists' Skepticism and Knowledge about Dissociative Identity Disorder in Adolescents

Statement of the Problem

Dissociative phenomena have been described in scientific literature for centuries (Ellenberger, 1970). One of the earliest descriptions of the diagnosis and treatment of a child with Dissociative Identity Disorder (DID), formerly called Multiple Personality Disorder (MPD), was written in 1840 by Antoine Despine, a French physician. In the introduction to his monograph describing the case of Estelle, a child with DID, Despine notes his “fear that generations to follow would not attend to the findings of their predecessor’s original mistakes” (Fine, 1988, p.38). Supporting Despine’s fears, DID was considered to be a rare disorder and rarely mentioned in psychology textbooks (Putnam, 1989).

Misdiagnosis of DID. Experts (Putnam, Guroff, Silberman, Barban & Post, 1986) on dissociative phenomena agree with Despine’s fears about his predecessor’s repeating mistakes about diagnosing DID. They reported on one hundred contemporary cases of adult DID’s that had been misdiagnosed, having received an average 3.6 incorrect psychiatric or neurological diagnoses, with an average 6.8 years between assessment for symptoms indicative of DID and accurate diagnosis. Other experts, (Alvarado, 1989) reviewing psychopathology in the 19th century, reported four cases of adolescents with

double personality and one case of multiple personality in a child; however, Steinberg (1996) notes no reported cases of DID in children between 1840 and 1979. Perhaps this discrepancy in reported numbers of cases of DID in children and adolescents is related to DID experts' experiences that scientific committees and journal reviewers are reluctant to present topics relevant to diagnosing DID in children and adolescents (Kluft, 1990). The inability of clinicians to find a scientific format to discuss information about DID is a formidable obstacle in establishing a basis to obtain scientific knowledge about DID.

Diagnostic obstacles. Other obstacles to diagnosing DID accurately in both adults and children are the seemingly baffling symptom complex: signs of DID can frequently be confused with other psychiatric diagnoses; the polymorphous symptom presentation or the presence of a coexisting disorder frequently makes the diagnosis of other psychiatric disorders the norm (Kluft, 1986; Lewis, 1996; Steinberg, 1996). The diagnosis of DID in children and adolescents is further complicated by a variety of factors: the need to differentiate between normal childhood fantasy involving imaginary companions and the alter personality states inherent in DID; the differentiation between normal childhood dissociation and pathological dissociation; the consideration of the less fixed symptomatology in children; the identification of childhood trauma and responses to the trauma; and the realization that abused children often move from one geographic place to another geographic place, thus, a complete data base of the child's history may be

lacking; in addition, abused children are likely to present denying problems (Lewis, 1996; Putnam, 1991; Steinberg, 1996).

Despite the knowledge that 100% of DID begins in childhood (Steinberg, 1996), as an adaptive dissociative response to childhood trauma (Kluft & Fine, 1989), the Diagnostic and Statistical Manual of Mental Disorder 4th editions {DSM-IV American Psychiatric Association, 1994) does not include a category for childhood dissociative disorders (Peterson, 1996) which may also be a factor for the low index of suspicion of DID in children (Peterson, 1996; Putnam, 1997; Steinberg, 1996). Nevertheless, there is a growing interest in childhood dissociative disorders as an outgrowth of clinical knowledge about adult dissociative disorders accumulated over the past two decades (Hornstein & Tyson, 1991). Fewer than 3% of DID patients are diagnosed under 12 years of age, while fewer than 8% are diagnosed in adolescence between the ages of 12 years of age and 19 years of age (Steinberg, 1996).

Low index of diagnostic suspicion factors. The recognition of childhood DID lags behind the recognition of adult DID (Putnam, 1991). Speculations concerning the lag in recognizing DID in children are due to a number of factors: the high level of professional skepticism about DID in the child psychiatric community (Putnam, 1991); the smaller numbers of clinicians and researchers in the child psychiatric community (Ross, 1996); the nature of the disorder per se and its precluding detection; the lack of typical or

baseline psychological profiles on clinical observation on psychological testing in children with DID; the natural history of DID; and the child's fear of ridicule or disbelief by others (McElroy, 1992). Causes for inaccurate diagnoses may be based on the clinician's disbelief that the child may be assuming a defensive posture against overwhelming trauma (Goodwin, 1985), or the clinician's wish to minimize pathology in order to rescue the child from receiving a controversial diagnosis such as DID (McElroy & McElroy, 1991).

Skepticism about DID. Similar to adult samples, the recognition and acceptance of DID in children is controversial. This controversy contributes to the limited information available on diagnosing DID in childhood and adolescents. No other mental illness elicits from clinicians such strong denials of the possibility of its existence. Surprisingly, clinicians who usually demonstrate an intense curiosity about other clinical phenomenon demonstrate an intense lack of interest in dissociative pathology (Hicks, 1985).

Researchers have explored skepticism about DID with professionals diagnosing and treating adult populations (Dell, 1988; Dunn, Paolo, Ryan & Van Fleet, 1994; Hayes & Mitchell, 1994). Dell's (1988) study surveyed 62 therapists who treated adults with DID. The findings affirmed the following: (a) the existence of professional skepticism; (b) disbelief in DID and under sensitivity to dissociative phenomenon among professionals not treating DID and; (c) dissociative diagnoses going unrecognized by

clinicians. Dunn, et al. (1994) surveyed therapists in the Veterans Administration Medical Center about their beliefs in DID. Findings indicated that while 80% of participants believed in DID, only 31% of the total sample completed the survey. Although this response rate is very much in line with statistical response rates for research surveys, Dunn, et al. (1994) further speculated that those who did not respond to the survey may be more skeptical of DID than those who did respond to it. Hayes and Mitchell (1994) surveyed a total of 115 mental health professionals (psychology, psychiatry, and social work) to study the nature of mental health professionals' skepticism about DID. There were greater amounts of skepticism associated with less knowledge about DID. Professionals who were not skeptical of DID and were knowledgeable about DID were younger ($M = 45.95$) than professionals ($M = 49.08$) who were skeptical about DID and had less knowledgeable about DID (Dunn, et al., 1994). Perhaps this reflects the fact that until the publication of the Diagnostic and Statistical Manual (DSM)-III in 1980, Multiple Personality was categorized under hysteria rather than as a specific diagnostic entity.

Importance of accurate, early diagnosis. Experts in the field of dissociation identify reasons for the importance of recognizing DID in children (Hornstein & Tyson, 1991; Kluft, 1990; Putnam, 1997). Since DID is sequelae of childhood abuse, the early diagnosis and intervention with the child and family may prevent continuation of the

abuse. Unlike their adult counterparts who may spend years in therapy, dissociative pathology in children and adolescents responds more rapidly to therapeutic intervention, which has an economic impact from both a fiscal and humanitarian perspective. While one can only speculate that the low index of suspicion for DID in childhood is related to a lack of knowledge about dissociative pathology across chronological developmental spans (pre-school, school age, adolescence) (Putnam, 1997), all research findings with adult populations (Dell, 1988; Dunn, et al., 1994; Hayes & Mitchell, 1994) concur that there is an inverse relationship between knowledge about DID and professional skepticism about DID among professionals. The less knowledge a participant had about DID, the more skeptical the participant was about DID.

One can hope that Putnam's desire (1997) that the knowledge about DID learned from diagnosing and treating adults will contribute to the knowledge base, rather than fuel old debates, about recognizing and treating DID in children and adolescents. Yet, clinical anecdotes and professional experiences in diagnosing DID in children indicate otherwise (Kluft, 1990; Peterson, 1997; Putnam, 1997). There are no studies to date on the nature of professional skepticism about DID within either the child or the adolescent psychology community. Thus, the problem statement is to investigate and to describe the presence or absence of professional skepticism about DID and about the nature of the

skepticism about DID among psychologists who diagnose and treat children and adolescents.

Purpose of the Study

Dissociative experts (Braun, 1988; Kluft, 1984; Peterson, 1996; Putnam, 1997) concur that DID in adults is the sequelae of childhood abuse that originated prior to six years of age. Developmental experts (Macfie, Cicchetti, & Toth, 2001) found that maltreated and nonmaltreated preschool-aged children followed different trajectories for dissociation: physically and sexually abused children demonstrated more dissociation than nonmaltreated children did. Yet, it is unusual for DID, the paradigmatic DD to be diagnosed in childhood and adolescents (Putnam, 1991). Speculations in the dissociative literature (Putnam, 1991) and anecdotal reports from psychologists who treat traumatized children and adolescents indicate skepticism about DID as well as a dearth of knowledge about the diagnosis of DID in childhood which may be correlated with the low percentages of accurate diagnosis of DID prior to adulthood (Steinberg, 1996). There are published studies (Dell, 1988; Dunn et al., 1994; Hayes & Mitchell, 1994) which find that professional skepticism about DID and a lack of knowledge about DID among professionals treating adults that impacts on diagnosis and treatment. However, there has not been any published study which queries psychologists treating children and adolescents about their beliefs about DID and knowledge about DID, the paradigmatic

DD. The purpose of this study is to investigate the absence or presence of professional skepticism about DID and to describe the nature of the professional skepticism about DID via measuring beliefs about DID that psychologists have who specialize in diagnosing and treating children and adolescents. The potential benefits of this study are:

- 1.) Ascertain descriptions of the beliefs about the diagnosis of DID among psychologists who treat children and adolescents.
 - 2.) Ascertain the level of knowledge about DID that psychologists have who treat children and adolescents.
 - 3.) Increase understanding within the field of psychology of the impact that professional beliefs about DID and knowledge about DID have on the accurate diagnosis of DID in adolescence.
 - 4.) Develop an empirical basis for the speculations and the anecdotal reports of psychologists who express skepticism and lack of knowledge about DID in children and adolescents.
 - 5.) Add to the knowledge base on diagnosis of dissociative pathology, within the child and the adolescent psychology community, contributing information relevant to early, accurate diagnosis of DID.
-

Rationale and Theoretical Background for the Study

Systems theory description. Systems theory is often used to understand underlying dynamics and processes of families. However, systems theory principles are also applicable to understanding the dynamics and processes in other groups of individuals such as psychologists. Wilson and Kneisl (1979) describe systems theory as:

A system is defined as an identifiable set of components characterized by a boundary, with interactions and interrelationships among the components. Anything that affects one part of the system affects every other part and the system as a whole. The combined interrelationships constitute a meaningful whole, and the system is greater than the sum of its parts (p. 827).

For this study, the identified system is the field of psychology; the components are identified as psychologists. Within this system, psychologists are divided into two subsystems: proponents of DID and skeptics of DID. These subsystems, proponents of DID and skeptics of DID, have an ongoing interaction and relationship with one another. As with any subsystem, the exchange of information between and among these subsystems is a dynamic process that is operationalized in professional publications and professional conferences on topics such as the etiology of dissociative pathology and the nature of memory relevant to the argument about the validity of the diagnosis of DID. Boundaries, wholeness, homeostasis, and open or closed traits characterize all systems and subsystems. Descriptions of systems' characteristics and selected illustrations of each

characteristic as applicable to the subsystems of DID proponents and DID skeptics is presented, using current and historical material.

Systems' theory principles. Boundaries describe who is in a particular system, their participation within the system, the degree of differentiation the system allows, their degree of investment within the system, as well as who and what is allowed outside of the system (Minuchin, 1974; Stuart & Sundeen, 1983). Boundaries may be rigid, enmeshed, diffuse, clear or conflictual. Conflictual boundaries are demonstrated between proponents of DID and skeptics of DID in their opposing views related to the etiology of DID. Proponents of DID (Kluft, 1984; Putnam, 1991) espouse a trauma based model of etiology for DID, but skeptics of DID (Spanos, 1994) espouse a sociocognitive model of etiology for DID. Thus, these etiological models present divergent beliefs about DID: proponents of DID believe that DID is sequelae of childhood trauma as opposed to skeptics of DID who believe that DID is a culture bound phenomena.

Wholeness is a vital aspect of systems theory. Wholeness means that components within the system of psychology are interdependent. Thus, a change or movement in any component of the system affects all other components of the system (Minuchin, 1974). Freud's views about hysteria, confided in a letter to Fleiss in 1897, influenced a movement away from the concept of dissociation to the concept of repression (Ellenberger, 1970), setting the historical precedent for the current debate about

dissociation versus repression that is part of the controversy about DID. Freud confided his reasons for abandoning the Theory of Hysteria: difficulties distinguishing unconscious memory from fiction; the large numbers of unnoticed father-daughter incest events seemed improbable; and the lack of therapeutic success (Ellenberger, 1970). Both proponents of DID (Gleaves & Freyd, 1997) and skeptics of DID (Lilienfeld, Lynn, Kirsch, Chaves, Sarbin, Ganaway, & Powell, 1999) continue to argue about these same issues: dissociation versus repression, the impact of trauma on memory, the veracity of accusations of abuse, and treatment outcomes for patients with DID.

Another systems theory principle espouses the idea that systems strive to achieve dynamic equilibrium or balance, a homeostasis. Homeostasis may be constructive or destructive. Unless a system can achieve a constructive balance within a range of functioning, objectives and tasks of the system cannot be accomplished (Wilson & Kneisl, 1979). In an effort to achieve a constructive balance between proponents of DID and skeptics of DID, Knapp (2000) reviews statements and position papers from professional associations on both sides of the recovered memory debate that add fuel to professional skepticism about DID. He acknowledges that there is professional consensus about child abuse, the nature of memory, and the standards for diagnosis of adults who have lost memories of abuse; there continues to be controversy about the nature and accuracy of memory.

Components in one system may also be components of another system. For example, psychologists are also components of: the health care system, professional organizations, and societal associations. Organizations such as the International Society for the Study of Dissociation (ISSD) and the International Society for Traumatic Stress Studies (ISTSS) tend to attract members who are proponents of DID; organizations such as the False Memory Syndrome Foundation (FMSF) tend to attract members who are skeptical of DID. The American Psychological Association (APA) has both proponents of DID and skeptics of DID in their membership, which may account for the organization's intentional decision to exclude terms such as "repressed memories", "recovered memories", "false memories", and "implanted memories" from the report of the Working Group on Investigation of Memories of Childhood Abuse. These terms are viewed by the Working Group members as having an emotional impact that makes rational scientific discussion improbable (APA, 1996).

A system may be open or closed. Open systems must have flexibility to adapt to the environment, but closed systems do not permit exchange of information between the system and the environment (Minuchin, 1974; Stuart & Sundeen, 1983). Peterson (1996) reviews his efforts to influence the DSM-IV Task Force to consider establishing a dissociative disorder for children, and to consider, further, his efforts with The Disorders Usually First Diagnosed During Infancy, Childhood and Adolescence Work Group to

include dissociative disorder in the differential diagnosis for other disorders commonly diagnosed in childhood and adolescence. Although these suggestions were not taken by the Task Force or the Work Group, other suggestions were taken: to identify children in the DID criteria; and to recognize dissociative disorder in the rule-out criterion for ADHD (Peterson, 1996). Hence, the system of psychology is open to adapting to information that is exchanged among professionals despite the controversy between proponents of DID who advocate for establishing a dissociative disorder for children in the DSM and skeptics of DID who advocate for eliminating dissociative disorder categories for children and adults in the DSM.

Review of Relevant Literature

Definitions of dissociation. Dissociation is defined in the DSM-IV TR (APA, 2000) as a defense mechanism with sudden, gradual, transient, or chronic disruption in the “usually integrated functions of consciousness, memory, identity, or perception of the environment” (p. 822). Automatic psychological defense mechanisms serve to protect individuals against anxiety and “from the awareness of internal or external dangers or stressors “ (p. 807). Dissociation is conceptually viewed on the Defensive Functioning Scale in the DSM-IV TR as a mental inhibition, or compromise level defense, protecting the individual by keeping “potentially threatening ideas, feelings, memories, wishes, or fears out of awareness” (p. 808).

Functions of dissociation. Dissociation is a defense mechanism that exists on a continuum ranging from normal states such as daydreaming to pathological states such as DID (Braun, 1988). Normative dissociation in adulthood involves daydreaming as well as highway hypnosis; normative dissociation in childhood involves fantasy play and the creation of imaginary companions (Fein, 1981; Putnam, 1995). Ross (1997) conceptualizes normal dissociation versus pathological dissociation across psychosocial and biological quadrants. The quadrants are: normal psychosocial; normal biological; abnormal psychosocial; and abnormal biological. While Ross (1997) considers being absorbed in a book or movie forms of normal psychosocial dissociation, he considers forgetting to use the bathroom during the night a form of biological dissociation. Ross (1997) illustrates the use of abnormal psychosocial dissociation as amnesia following incest or physical abuse, but amnesia as a consequence of a head injury as illustrative of biological dissociation in both adults and children.

Experts (Ross, 1997; van der Kolk, 1987) in the field of dissociation view dissociation as a means of organizing information, as a process that produces alterations in an individual's feelings, thoughts, or actions, and as a way of compartmentalizing one's experience. In addition to serving as a defense against stress and overwhelming trauma, Ludwig (1983) describes other values and functions of dissociation:

Dissociation represents the fundamental psychobiological mechanism underlying a wide variety of altered forms of consciousness, including conversion hysteria, hypnotic trance, mediumistic trance, multiple personality, fugue states, spirit possession and highway hypnosis. This mechanism has great individual and species survival value. Under certain conditions, it serves to facilitate seven major functions: (1) the automatization of certain behaviors, (2) the efficiency and economy of effort, (3) the resolution of irreconcilable conflicts, (4) escape from the constraints of reality, (5) the isolation of catastrophic experiences, (6) the cathartic discharge of certain feelings, and (7) the enhancement of herd sense (e.g. the submersion of the individual ego for the group identity, greater suggestibility, etc.) (p. 93).

Maldonado and Spiegel (1994) describe the utility of dissociation for individuals faced with overwhelming trauma:

Dissociative states can be viewed as efforts to preserve some form of control, comfort, safety, and identity when faced with overwhelming stress. They give the victim a false sense of control and relief from the experience, so that it is as if the event is not happening and, later, as if it had never happened (p.228).

Experts (Kluft, 1985; Peterson, 1997; Putnam, 1989; Ross, 1997; van der Kolk, 1987) in the field of trauma and dissociation concur that dissociative states are common and normative experiences in both adulthood and childhood; these experts also concur that dissociation which is used to adapt to trauma that occurs over time can be reinforced, evolving into a maladaptive defensive functioning. Putnam (1989) notes that “disruption of normal integrative functions has been the critical issue of definitions of dissociation” (p. 6). Lowenstein (1991) views DID as a “complex form of posttraumatic dissociative

developmental disorder primarily related to severe, repetitive childhood abuse or trauma usually beginning before the age of five” (p. 721). This functioning provides the traumatized child with a psychological escape from overwhelming trauma. Nemiah (1981) notes that pathological dissociation involves experience in identity alteration; it also involves experience in memory disturbance for events that occur during a dissociative episode. Nemiah’s (1981) views about identity alteration and memory disturbance are among the characteristics cited in the forms of Dissociative Disorders (DD) described in the DSM-IV TR.

Features of dissociation in DSM-IV-TR. Ellenberger (1970) and Goettman, Greaves, and Coons (1994) have reviewed the two hundred-year history of dissociative pathology documented in the French, German, and English psychological literature. However, it was not until the DSM-III (APA, 1980) publication that the United States psychiatric community crystallized dissociative disorders as a psychiatric diagnostic category. The DSM IV-TR notes that the essential feature of the Dissociative Disorders (DD) is a “disruption in the usually integrated functions of consciousness, memory, identity, or perception” (p.519). The five forms of DD cited in the DSM-IV-TR are: 1) Dissociative Amnesia (formerly called Psychogenic Amnesia); 2) Dissociative Fugue (formerly called Psychogenic Fugue); 3) Depersonalization Disorder; 4) Dissociative Identity Disorder (DID) (formerly called Multiple Personality Disorder); and 5)

Dissociative Disorder Not Otherwise Specified (DDNOS) (formerly called Multiple Personality Disorder Not Otherwise Specified).

Forms of dissociative pathology. Dissociative amnesia is characterized in the DSM-IV-TR as “an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness” (p. 519). Dissociative fugue is characterized in the DSM-IV-TR as “sudden, unexpected travel away from home or one’s customary place of work, accompanied by an inability to recall one’s past and confusions about personal identity or assumption of a new identity” (p.519). Coons (1998) notes that dissociative fugue is dissociative amnesia plus travel. Depersonalization disorder is characterized in the DSM-IV-TR by “a persistent or recurrent feeling of being detached from one’s mental processes or body that is accompanied by intact reality testing” (p.519). Coons (1998) notes that transient depersonalization symptoms can be present in the other dissociative disorders, dissociative amnesia, DDNOS, and DID. The diagnosis of depersonalization disorder cannot be made if the depersonalization occurs as part of any other psychiatric disorder such as panic disorder, posttraumatic stress disorder, or schizophrenia (Coons, 1998). DID is characterized in the DSM-IV-TR by “the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behavior accompanied by an inability to recall important personal information that is too extensive

to be explained by ordinary forgetfulness” (p. 519). Coons (1998) notes that DID includes the amnesia, the fugue, and the depersonalization characteristics specified in the other dissociative disorders. Perhaps this is the underlying reason that DID is considered to be the paradigmatic DD, because if a therapist can diagnose DID then the therapist can diagnose any of the less complex dissociative states (Fine & Madden, 2000). DDNOS is described in the DSM-IV-TR as useful for “coding disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific Dissociative Disorder” (p. 519).

Development of Diagnostic Criteria for DID. With the publication of the Diagnostic and Statistical Manual Third Edition (DSM-III), Multiple Personality (MP) became a distinct disorder separate from the prior category of Hysterical Neurosis, Dissociative Type (American Psychiatric Association, 1980; Peterson 1996; Putnam, 1994). The change in nomenclature has been attributed to clinicians who were beginning to recognize that trauma was associated with psychological as well as physiological sequelae, largely as an outcome of the Viet Nam war and the Feminist movement (van der Kolk, 1987). With the advent of the Diagnostic and Statistical Manual Third Edition Revised (DSM-III-R), the nomenclature was again changed to Multiple Personality Disorder (MPD) (American Psychiatric Association, 1984). The content of the DSM-III-R changed the diagnostic criteria for MPD, with the inclusion of amnesia as well as the

need for the clinician to rule out substance, medical, and developmental disturbances (Peterson, 1996).

With the advent of the Diagnostic and Statistical Manual Fourth Edition (DSM-IV), MPD nomenclature was again changed to Dissociative Identity Disorder (DID), reflecting the Task Forces' efforts to convey the concept of a proliferation of identities rather than a proliferation of personalities (American Psychiatric Association, 1994).

The DSM-III cited that the onset of MP occurs in early childhood or later, rarely being diagnosed until adolescence. However, it was not until the DSM-IV (American Psychiatric Association, 1994) that Criterion D cautioned that symptoms in children could not be better attributed to imaginary companions or fantasy, and that DID was included as a differential diagnosis and rule-out criterion for Attention Deficit Hyperactivity Disorder (ADHD) (Peterson, 1996). The DSM-IV Task Force was concerned that DID would be over diagnosed, electing not to include dissociative disorders as a differential diagnosis in other diagnostic categories (Weiner, England, Frances, First, Wise, Holland, & Williams, 1995).

DSM-IV-TR diagnostic criteria for DID. The Diagnostic and Statistical Manual Fourth Edition Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000) continued to use the DID nomenclature, and modified the textual content from the DSM-IV's text. The DSM-IV-TR modifications focus on cultural issues, noting that cases of

DID “have been documented in a variety of cultures around the world” (p. 528), and that the symptomatology of dissociative disorders may “take different forms in different cultures, such as recurrent brief episodes of dissociative stupor or spirit possession in India” (p. 519). The DSM-IV-TR cites the following criteria for the diagnosis of DID:

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person’s behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts, or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play (p.529).

Rationale for DID diagnostic criteria. Peterson (1996) reviews the purpose for each of the criterion stated in the DSM-IV, which are equally applicable to the DSM-IV-TR criteria:

- 1) Purpose of Criterion A is: to describe that the person experiences autonomous self-states and to establish the nature and complexity of the self-states. 2) Purpose of Criterion B is: to determine that the self-states take over control of the person’s behavior. 3) Purpose of Criterion C is: to distinguish that amnesia is present. 4) Purposes of Criterion D are: to rule out substance abuse or medical conditions and to exclude phenomena found in normal childhood (p. 4).

The DSM-IV represents a substantial gain in recognizing DID in children. Peterson (1996) comments “no longer will an informed child psychiatrist order the clinician to show me where it is in the DSM” (p.11). Perhaps the lack of knowledge about child and adolescent DID could be attributed to the fact that the first text devoted to dissociative disorders in children was not published until the mid-1980’s (Kluft, 1985). However, information and research about dissociative disorders in children and in adolescents is rapidly growing (Peterson, 1996) rather than continuing to be gleaned from the adult literature on dissociative pathology. Nevertheless, experts in diagnosing DID in children and in adolescents still believe that accurate diagnosis of DID depends upon improving clinical descriptors of DID in children and in adolescents, as well as in more developmentally suitable diagnostic criteria (Dell, 2001; Peterson, 1996; Putnam, 1994, 1996).

Prevalence of DID. The DSM-IV TR statement related to the prevalence of DID in the United States encapsulates the essence of the controversy surrounding the diagnosis of DID:

Some believe that the greater awareness of the diagnosis among mental health professionals has resulted in the identification of cases that were previously undiagnosed. In contrast, others believe that the syndrome has been over diagnosed in individuals who are highly suggestible (p.528).

Ross (1997) observes that there has been an exponential increase in the diagnosis of DID not only in North America, but also in other countries such as Turkey, Norway, Japan, The Netherlands, Australia, and New Zealand. Lowenstein (1993) believes that dissociative disorders are the most common psychiatric disorders in the world. The DSM-IV-TR lends credence to these dissociative experts' observations, noting that cases of DID "have been documented in a variety of cultures around the world" (p.839).

Prevalence data on children and adolescents with dissociative disorders is sparse with only 10% of DID cases diagnosed prior to age twenty (Kluft, 1985). Of those diagnosed prior to age twenty, 3% were under twelve years of age and 8% were between 12 and 19 years of age (Kluft, 1985). A more recent study found that of 231 children and adolescents admitted for treatment, 23% met the DSM-III-R diagnostic criteria for DID (Waterbury, 1991). DID is, however, more commonly diagnosed in individuals in their late twenties to early thirties (Horevitz & Braun, 1984; Putnam, et al., 1986).

Kluft (1985) reports that 20 adult patients meeting the criteria for DID had been in therapy for more than 10 years without the clinician considering a DID diagnosis. Researchers of adult populations have estimated a time frame of six to seven years from the time a patient enters the mental health system, each reporting an average of 6.8 other diagnoses, before receiving a diagnosis of DID (Coons, Bowman, & Milstein, 1988; Ross Norton, & Wozney, 1989). Hornstein and Putnam (1992) found that children in their case

series had received an average of 2.7 inaccurate psychiatric diagnoses prior to the diagnosis of DID or Dissociative Disorder Not Otherwise Specified (DDNOS) with the accurate diagnosis of DID or DDNOS more often made in the adolescent than in the children's population.

Epidemiology of DID. Epidemiological findings suggest a higher rate of dissociative disorders than previously considered (Putnam, 1995; Ross, Joshi & Currie, 1989). Putnam (1995) estimates that approximately 1 % of the North American general population and 3% to 5% of North American psychiatric patients meet criteria for a dissociative disorder. Researchers report that 1% to 10% of all psychiatric patients meet the dissociative disorder diagnostic criteria (Bliss & Jeppsen, 1985; Ross, 1991; Ross, Anderson, Fleisher, & Norton, 1991; Ross, Norton, & Wozney, 1989). Ross (1997) speculates that 5% to 10% of children in the United States will develop a dissociative disorder prior to the age of 18.

Despite controversy surrounding the diagnosis of DID, there is a consensus that DID is sequelae of early childhood traumatic experiences often involving sexual and physical abuse or neglect of a child who uses dissociation as a defense against the overwhelming feelings related to the trauma (Putnam, 1985; Swica, Lewis & Lewis, 1996). The National Institute of Mental Health (NIMH) found that 97 percent of adult DID patients reported sexual, physical, and emotional abuse during childhood although

skeptics of DID question the methodology of this study as the research lacks outside corroboration that the reported trauma actually occurred (Putnam, 1989).

Gender issues. The ratio for male to female adults with DID ranges from 1 to 4 to 1 to 9 (American Psychiatric Press, 1994; Ross, 1997; Schultz, Braun, & Kluft, 1989). However, research with male prison populations suggests a high rate of DID (Allison & Schwarz, 1980) lending credence to Putnam's (1993) speculations that males with DID are more likely to be found in the criminal justice system and in addiction treatment populations, but females with DID are more likely to be found in the mental health system. Hacking (1995) concurs with Putnam (1993) speculating that males with DID will come not only from the justice system but also from the veterans' administration where trauma disorders are common. Differing from Putnam (1993), Hacking (1995) believes that the diagnosis of DID is more prevalent for females as a consequence of clinicians' attitudes towards gender rather than in attitudes towards dissociative pathology.

Dell and Eisenhower (1990) hypothesize that children and adolescents with DID may increase the prevalence rate of DID in males because disturbed male children create more chaos than disturbed female children, bringing the male children and adolescents to the attention of mental health providers. Perhaps their hypothesis will be supported as gender ratios are more fully equilibrated in children and in adolescents with DID than in

the gender ratios of their adult counterparts. Although sample sizes are small, findings for male to female ratios of children and adolescents diagnosed with DID are closer to 1 to 1 (Vincent & Pickering, 1988; Waterbury, 1991).

Theoretical models of dissociation. Navajits (1997) emphasizes the fact that theory is created from beliefs and that implicit theory, or private assumptions, stem from explicit theory; both are fallible. The beliefs and private assumptions of proponents and skeptics of DID are elucidated from divergent etiological pathways. Proponents of DID utilize the trauma-based pathway; skeptics of DID, however, utilize the iatrogenic pathway. Contemporary theoretical models that will be described are: the BASK Model (Braun, 1984, 1988); Four-Factor Theory (Kluft, 1986); the Discrete Behavioral State Theory (Putnam, 1989, 1997); and the Sociocognitive Model (Spanos, 1994, 1996).

The BASK model. Braun's (1988) BASK model of dissociation is an acronym for Behavior, Affect, Sensation, and Knowledge formulated from a psychobiological perspective of state dependent learning. Braun (1988) posits that when behavior, affect, sensation, and knowledge are congruent, parallel processes on a time continuum, there is a stable consciousness. The BASK model posits that dissociation may involve separation of one, or any combination of the normally integrated functions of behavior, affect, sensation, and knowledge in response to a stressor. Braun (1984) speculates that:

Multiple personalities... are created via repeated dissociation that occurs under extreme stress, most often child abuse. These dissociations often have similar affective states...that chain them together so that they can develop a history...range of emotions...and set response patterns (p.63).

Braun (1988) posits that dissociative response patterns, reinforced by repeated abuse, interrupt the congruency of behavior, affect, sensation, and knowledge so that the brain encodes experience in a dissociative, fragmented manner. Braun's (1988) model functions as a paradigm for clinically assessing a range of dissociative states from normal daydreaming to DID, serving to monitor clinical changes over time of a traumatized patients' behavior, affect, and cognition (Fine, 1990).

The Four-Factor Theory. Kluft's (1984) Four-Factor Theory posits that DID develops when a child has the capacity to dissociate (Factor 1), and when traumatic life experiences overwhelm the child's adaptive non-dissociative capacities (Factor 2). Kluft (1987) views the potential for dissociation as a biological element of hypnosis, finding that abused individuals score higher than non-abused individuals on hypnotizability and dissociation. Other researchers (Bliss, 1983; Frishholz, 1985; Spiegel, 1991) concur with Kluft (1987) in finding that DID patients are biologically highly hypnotizable. Ganaway (1989) views dissociation phenomenologically, as a capacity for auto-hypnotic trance experiences.

Cross sectional developmental studies (Macfie, et al., 2001) find that dissociation normally decreases during a child's pre-school years, and that adolescents demonstrate less dissociation than younger children. Research findings related to Factor 2 support a positive correlation between trauma (sexual abuse, physical abuse, and neglect) and dissociation for children from preschool through late adolescence, finding that maltreated children do not follow the normative dissociation trajectory found in cross sectional developmental studies: the older the child, the less dissociation (Hornstein & Putnam, 1992; Macfie, et al., 2001; Putnam, 1996; Ross, 1997).

Kluft (1984) posits the idea that available natural psychological substrates are utilized to develop personality formations (Factor 3), and the failure of significant others to protect the child against further overwhelming trauma leads to the fixation of separateness (Factor 4). The shaping influences and substrates can determine the form of dissociative defense, and this absence of protection leads to a failure in soothing, restorative experiences. Kluft (1986) conceptualizes the phenomenological expression of DID as the final common pathway in "a unique configuration of intrapsychic structures and dynamics and environmental influences" (p.88). Kluft (1991) identifies shaping influences related to Factor 3: contradictory parental demands, reinforced role-playing, non-supportive environments, multiple caretakers, double-bind messages and the presence of a DID parent, as was noted in Braun's (1985) transgenerational research on

dissociation. In Factor 4, the lack of protection for the child is a major factor in the continuation of the child's experiencing ongoing trauma as well as in developing maladaptive dissociative response patterns to escape the inescapable trauma.

The discrete behavioral states model. Putnam's (1997) discrete behavioral states model is a developmental approach, extrapolated from research of infant behavioral states, positing three substrates for the development of DID: a human being's capacity to develop DID; an ability to enter a dissociative state; and the ability to fantasize and project personality onto objects and situations. Congruent with other proponents of DID (Braun, 1984; Kluft, 1984; Ludwig, 1983), Putnam (1989) views dissociative states as adaptive responses that function to provide:

1) escape from the constraints of reality; 2) containment of traumatic memories and affects outside of normal conscious awareness; 3) alteration or detachment of sense of self (so that the trauma happens to someone else or to a depersonalized self); 4) analgesia (p.53).

Putnam (1989, 1997) describes the organization of human behaviors as a series of discrete states that are present at birth and smoothed out as development occurs so that transition between these states is difficult to detect as an integrated sense of self develops. Putnam (1989,1997) notes that these series of discrete behavioral states present in infants suggest that all human beings are born with the potential for developing DID. Putnam (1989) describes DID as "a psychobiological response to a relatively specific set of

experiences occurring within a circumscribed developmental window” (45). Putnam (1997) posits that similar psychobiological mechanisms may be present in mood disorders as he draws parallels between the affective states demonstrated in individuals having mood disorders with the discrete states exhibited by individuals having DID, comparing switches between affective states to the state transitions and switches of individuals with DID.

Putnam (1989) posits that since children have a high normative capacity to enter dissociative states, children are prone to use dissociation as a defensive function when faced with overwhelming trauma. A child’s ability to enter a dissociative state is conceptualized by Putnam (1989) as “significant alterations in the integrative functions of memory for thoughts, feelings, or actions, and significant alterations in sense of self” (p. 52). Putnam (1997) predicts that increased recognition of DDs in childhood will result in a rapid rise in the numbers of diagnosed cases. As with adults, the rapid rise may be mistaken as evidence of iatrogenesis, adding fuel to the controversy between trauma-based versus iatrogenic pathways and between proponents and skeptics of DID.

The sociocognitive model. The sociocognitive model posits the idea that DID, like other forms of multiple identity role enactments, is a socially constructed, context-bound, goal-directed, social behavior dependent upon others’ expectations; furthermore, the changes in identities over time are to meet changing expectations of others in varied

social contexts (Spanos, 1996). Within this model, DID is conceptualized as the North American version of contextually dependent multiple identity role enactments, a social construct, rather than a valid psychiatric diagnosis (Kenny, 1998). Role enactments of multiple selves are not the product of conscious deception, as no conscious awareness is involved; DID is viewed as the product of the social roles required to meet the demand characteristics of various social contexts (Lilienfeld, et al., 1999). Thus, trauma based and iatrogenic based models have congruency in two areas: the experience of multiple self-states is not a deception, and there is not a conscious awareness in the production of the experience of multiple self-states. The issue of deception remains controversial as researchers (Dinwiddie, North, & Yutzy, 1993) found that DID, especially in forensic cases, could not be differentiated from malingering, yet other researchers (Lewis, Yeager, Swica, Pincus, & Lewis, 1996) found cases of childhood symptomatology of DID in adults convicted of murder that could differentiate DID from malingering.

Proponents of the sociocognitive model view the etiology of DID as stemming from varied social contexts such as the relationship between the therapist and the patient (Lilienfeld, et al., 1999). Spanos (1994) postulates that iatrogenic factors attributed to the therapist include suggesting multiplicity, utilizing hypnosis to produce the symptom profile, and contributing to the shaping of the multiple identity enactments via reinforcement. The iatrogenic factors attributed to the patient are media and book

presentations of multiple identities such as Sybil and Eve, and meeting the therapists' expectations (Spanos, 1994).

Spanos searches for a scientific account of the social contexts that condition individuals for multiple identity role enactment, yet discounts the research of DID proponents such as Kluft, Putnam, and Ross, suggesting that they are also participants in the social construction of a reality that produces multiple personalities (Bieber, 1998). Perhaps, this accounts for Spanos' (1994) belief that DID is the creation of a handful of therapists who are responsible for the increased numbers of reported cases of DID; this is in opposition to the idea that the increase in numbers of reported cases of DID is correlated to changes in establishing a separate diagnostic category of dissociative pathology and research based screening and diagnostic instruments

Need for diagnostic instruments for DID. Berenson (1998) cites factors relevant to frequently missed diagnoses in child and adolescent psychiatry: symptom overlap; clinical training that emphasizes adherence to DSM criteria rather than the exploration of risk factors, current stressors, culture, and family dynamics; high rates of co morbidity; informed observers' perceptions; and developmental influences on symptomatology. Research findings on prior diagnoses of children with DDs indicate that ADHD, psychotic disorders, mood disorders, and oppositional conduct disorders were the most commonly cited prior diagnoses (Hornstein & Tyson, 1991; Peterson, 1996). These

research findings relevant to missed DDs diagnoses in children and adolescents lend credence to both proponents and skeptics of DID that there is a need for the following instruments to assess for dissociative pathology in children and adolescents: the Child Dissociative Checklist (CDC), The Adolescent Dissociative Experiences Scale (A-DES), and The Structured Clinical Interview for DSM-IV Dissociative Disorder (SCID-D).

Child Dissociative Checklist. Putnam and Peterson (1994) note that the development of the Child Dissociative Checklist (CDC) derived from two sources: prior childhood DID predictor lists (Fagan & McMahon, 1984; Kluft, 1984; Putnam, 1985) and clinical experience with children with DDs (Steinberg, 1996). The CDC is intended to be completed by someone familiar with the child's behaviors across a number of contexts (school, home, or play) over the preceding 12-month period. The form is completed by parents, foster parents, teachers and other adults in close contact with the child in both inpatient and outpatient settings; there are the usual accuracy and objectivity limitations of observer reports. Friedrich (1993) found that mothers of sexually abused children, who have often have been sexually abused themselves, demonstrated wide variations in accuracy in reporting their children's behaviors, and, in fact, children with DID often do have sexual abuse histories (Hornstein & Tyson, 1991).

The 20 item behavioral CDC for preadolescents encompasses the following dissociative behaviors: (1) dissociative amnesias; (2) rapid shifts in: demeanor, access to

information, knowledge, abilities and age appropriateness of behavior; (3) spontaneous trance states; (4) hallucinations; (5) alterations in identity; and (6) aggressive and sexual behavior (Putnam, 1994). The CDC provides a rapid, cost-effective way to screen for pathological dissociation in children, but it may also function as a monitor of treatment when administered serially (Nader, 1997). When used as a research tool, the CDC can quantify dissociative behavior for dimensional approaches to dissociative phenomenon (Putnam, 1997; Steinberg, 1996). The CDC has undergone unauthorized revisions thus Putnam and Peterson (1994) caution clinicians and researchers that the established reliability and validity apply only to the authorized versions of the CDC to determine the presence or absence of dissociative pathology in children (Putman, 1997). Translations of the CDC are still in progress (Nader, 1997). The as yet unknown influences of other cultures on CDC scores (Putnam, 1997) has the potential to fuel the acrimonious debate between proponents and skeptics of DID, as both sides acknowledge the fact that culture may influence how one views dissociative processes (Putnam, 1997; Spanos, 1996). The use of the CDC is limited during adolescence since informed observers do not have as much access to the details of teen lives as compared with those of younger children (Putnam, 1997). Thus, self-report scales and diagnostic structured interviews are considered more feasible to screen for dissociative pathology in adolescence.

The Adolescent Dissociative Experiences Scale. The Adolescent Dissociative Experience Scale (A-DES) is a 30-item self-report measure based on the following constructs related to dissociation: amnesias, depersonalization, derealization, passive influence, identity alteration, and absorption (Armstrong, Carlson, Putnam, Libero, & Smith, 1997). The purpose of the A-DES is to screen, primarily adolescents for dissociative disorders; it is intended to be used from ages 10-21 (Steinberg, 1996). Preliminary studies indicate that the A-DES is a reliable and valid measure (Armstrong et al., 1997; Putnam, 1997). Unlike the CDC, the A-DES has been translated into German to investigate a spectrum of traumatic events for mediating factors in the development of dissociative pathology in adolescents (Brunner, Parzer, Schuld, & Resch, 2000), providing the potential for researchers to investigate for cultural influences on both normative and pathological dissociation.

The A-DES differs from the adult Dissociative Experiences Scale (DES) in design, construct, and language, yet the cautions cited by Coons (1998) regarding DES scores may be also applicable to the A-DES scores. Coons (1998) cautions clinicians that DID patients may achieve normal scores related to denial or unawareness of symptoms; individuals attempting to fake DID may have scores in any range, depending on their knowledge of the symptoms they are simulating; other psychiatric illnesses such as

posttraumatic stress disorder, schizophrenia, and borderline personality have been known to obtain high scores on the DES (Coons, 1998).

Structured clinical interview. The Structured Clinical Interview for Dissociative Disorders (SCID-D) is a clinician administered, structured interview that focuses on the five core dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, and identity alteration) allowing clinicians to make diagnoses of dissociative disorders based on DSM-IV criteria (Steinberg, 1994). The SCID-D, which requires interviewer training, has good reliability and validity, based on extensive field trials funded by the National Institute of Mental Health (NIMH) (Steinberg, 1996).

Nevertheless, the SCID-D, requiring 2-3 hours to complete, consists of 250 items, and the open-ended questions require not only supervised training, but also clinical sophistication for the interviewer (Putnam, 1997). Although originally designed for use with adult populations, the SCID-D has also been reliable in diagnosing dissociative pathology in adolescents as young as 14-years of age (Steinberg & Steinberg, 1995).

Proponents of DID can hope that the use of objective instruments and structured interviews designed to assess for dissociative pathology will improve diagnostic accuracy; however, skeptics of DID are likely to view increased case numbers of children and adolescents with DID as attributable to a handful of clinicians who are proponents of DID. This is due to the fact that the usual battery of psychological testing for children and

adolescents cited in textbooks for assessment does not include assessing for dissociative pathology (Silberg, 1994).

Diagnostic Features Profile and psychological testing. Individually administered psychological testing protocols remain the primary modality for describing psychopathology in clinical work with children, but standard psychological testing protocols do not usually include instruments focused on dissociative pathology. Silberg's (1996) Diagnostic Features Profile (DFP) was designed to operationalize features of dissociation, present during the testing process for dissociative children and adolescents. Since these features are rarely seen in non-dissociative children and adolescents, this may prove useful in early diagnosis of traumatized children, especially when there is blurring of boundaries between diagnoses. The research to ascertain unique or discriminating patterns of test responses in children suspected or diagnosed with DDs utilized a standard test battery that included: Wechsler IQ tests (Wechsler Preschool and Primary Scale of Intelligence-Revised, or Wechsler Intelligence Scale for Children-III), the Rorschach Test, the Thematic Apperception Test (TAT), the Sentence Completion Test, and drawing tasks in conjunction with the CDC and the DFP (Silberg, 1998). Findings indicated that the DFP behavioral variables more common in the dissociative group than in the control group were: forgetting, staring, unusual motor behaviors, dramatic fluctuations, fearful and angry reactions to stimuli, physical complaints during testing, and expressions of

internal conflicts. The DFP response markers more common in the dissociative group than the control group were: images of multiplicity, malevolent religiosity, dissociative coping, depersonalized imagery, emotional confusions, extreme dichotomization, images of mutilation and torture, and magical transformation (Silberg, 1998). Results indicated that the DFP behavioral and response variables selected 93% of the dissociative sample, lending support to the discriminative validity of DID and DDNOS as diagnostic categories in childhood. There are congruent parallels between the dissociative behavioral variables and response markers during psychological testing of children and adolescents who were investigated and with the polysymptomatic presentation of dissociative pathology.

Polysymptomatic Phenomenon and Differential Diagnosis Issues

Diagnostic enigma: contemporary and historical views. Breuer and Freud's nineteenth century case of Anna O., a 21 year-old female, is cited as a diagnostic enigma in the APA's (1994) "DSM-IV Casebook" illustrating the long-standing diagnostic symptom configuration inherent in cases presenting with dissociative pathology. Case discussants "doubt that many clinicians at the present time see patients quite like Anna O." (APA, 1994, p.515), who was originally diagnosed with hysteria.

Discussants cite the chief complaint of Anna O. as numerous physical symptoms (cough, headaches, visual disturbances, contractures, anesthesia of extremities) noting that the diagnosis congruent with DSM-IV criteria would be Conversion Disorder. Anna

O.'s depressive symptoms (sleeplessness, suicidal ideation), subsequent to her father's death, do not meet the time criteria for a diagnosis of Major Depressive Episode. Her symptoms of alternating states of consciousness (sleep-like states, imagining the experience of childbirth) are indicative of a DD. Since the discussants do not believe that these clinical descriptors meet specific DSM-IV criteria, the diagnosis is DDNOS. Anna O.'s symptoms indicative of a psychotic disorder (disorganized speech, hallucinations, possible delusions) lead to an additional diagnosis of Schizophrenia; yet, this does not "capture the essence of Anna O.'s illness" (APA, 1994, p.515). Hence, a Psychotic Disorder, Not Otherwise Specified is added to account for the nature of her psychotic symptoms. Although the discussants considered a diagnosis of Factitious Disorder with Psychological symptoms, they ruled this out on the basis that neither Breuer nor Freud believed that she was intentionally exhibiting these symptoms. Thus, the discussants considered six different diagnoses from six different symptom configuration perspectives, settling on five different diagnoses to account for the polysymptomatic clinical picture of Anna O.

Proponents of DID (Bliss, 1986; Kluft, 1993, Ross, 1989) do not concur with the case book discussants' assertion that cases such as this are not often seen by contemporary clinicians and they view the case of Anna O. as a classical presentation of a

single case study of DID that is representative of contemporary cases of DID. Breuer described the complex, clinical presentation of Anna O. as:

Two entirely distinct states of consciousness were present which alternated very frequently and without warning and which became more and more differentiated in the course of the illness. In one of these states she recognized her normal surroundings; she was melancholy and anxious, but relatively normal. In the other state she hallucinated and was “naughty” – that is to say, she was abusive, used to throw the cushions at people, so far as the contractures at various times allowed, tore buttons off her bedclothes and linen with those of her fingers which she could move, and so on. (Breuer & Freud, 1896, p.76).

The polydiagnostic views of the case discussants as opposed to the views of proponents of DID may have led Putnam (1991) to the suggestion that when clear, dissociative pathology exists in combination with other diagnostic categories, then the DD should be considered the super-ordinate diagnosis. While Anna O. presents an adult case, the complexities of psychiatric diagnoses presented by case discussants and proponents of DID are also applicable to children and adolescents. Hornstein and Putnam’s (1992) research found that 80-90% of children and adolescents with DDs exhibited posttraumatic stress disorder symptoms. The need to approach diagnosis as a “superficial thought-organizing tool that may either enhance or interfere with a real understanding of an individual’s difficulties” (Hornstein, 1996 p.43) is vital to resolving diagnostic enigmas.

The interest in identifying cases of DDs in children and adolescents was founded on contemporary clinicians' experiences with adults who described their experiences of the onset of DID as occurring in childhood (Kluft, 1996). As with nineteenth and twentieth century predecessors (Alvarado, 1989; Bowman, 1990; Ellenberger, 1970; Fine, 1988), single case report publications of DID in children and adolescents increased during the 1980's (Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Kluft, 1984). Single case reports culminated in large case series research to accumulate data systematically on separately diagnosed samples of children and adolescents with dissociative pathology (Hornstein & Putnam, 1992; Peterson & Putnam, 1994). Data presented in single case reports and in large case series research findings led to the development of diagnostic instruments and interviews for DDs as well as in clinicians developing a framework to organize the complex symptom presentation for both diagnostic and treatment consideration (Hornstein, 1993, 1996; Putnam, 1997; Steinberg, 1996).

Organizational framework of dissociative pathology. Peterson (1990) organized the most common behaviors manifested by pathologically dissociating children into the following categories: dissociative symptoms, process symptoms, behavioral symptoms, affective symptoms and posttraumatic symptoms. The dissociative symptoms cited are amnesia, trance-like behaviors and perplexing behavioral fluctuations. The process

symptoms cited include imaginary companionship, internal auditory hallucinations, and passive influence experiences. The behavioral symptoms cited are conduct problems, aggression, risk taking, and self-destructive behaviors. The affective symptoms cited are depression and explosive anger. The posttraumatic symptoms cited are disturbances in sleep, hypervigilance, and intrusive imagery. Obviously, these symptoms and behaviors are not exclusive to dissociative pathology (Hornstein, 1996; Lewis, et al., 1996; Peterson, 1990; Putnam, 1997), requiring the clinician to consider alternative diagnostic considerations, and requiring clinicians unfamiliar with the symptom presentation of childhood and adolescent dissociative pathology, and diagnostic uncertainty, to consult with clinicians knowledgeable about dissociative pathology in children and adolescents. (Hornstein, 1996).

Guidelines to differential diagnosis of DID. Diagnostic symptoms such as hallucinations, attentional focus and memory problems are not diagnostically specific (Hornstein, 1996). Thus, Nemzer's (1996) behaviorally based guide to differential diagnosis for DID in children and adolescents may prove a useful tool to resolving diagnostic enigmas. Nemzer (1996) differentiates DID from schizophrenia, mania, depression, PTSD and ADHD along eight dimensions: attention and memory problems, aggression, risk-taking, self-injury, mood and mood lability, sleep problems, anxiety and hyperarousal, and thought disorder. In patients with attention and memory problems the

clinician can differentiate DID from ADHD by comparing and contrasting the presentation of attention and memory problems in DID with ADHD. In those with DID, attention and memory problems are too extensive for ordinary forgetfulness. Memories are variable or absent. Information is often self-contradictory, appearing to be disorganized. Trance states are common and the individual is inconsistently inattentive. On the other hand, attention and memory problems in ADHD present as sensitivities to non-specific external stimuli. Unlike the DID patient, the patient with ADHD has a consistent distractibility and a short attention span.

Nemzer (1996) differentiates DID from schizophrenia on the thought disorder dimension, noting that with DID hallucinations are experienced as internal, often identifiable voices, and reality testing is intact; however, in schizophrenia auditory hallucinations are experienced as external, voices are unintelligible or whispering, and reality testing is impaired. The anxiety and hyperarousal of the DID patient is demonstrated in hyper-reactivity and hypervigilance. The patient is easily startled, and panics when someone resembles the perpetrator; on the other hand, the schizophrenic patient's anxiety, correlates to paranoid or delusional thinking. With DID, the patient self-injures to relieve tension or numbing, often feeling detached from the event as if it were not happening to him or her as if the injury might be due to a punitive alter personality; with schizophrenia, the patient self-injures due to paranoid or delusional

thinking. Although both DID and schizophrenic patients exhibit a reckless disregard for danger, the DID blocks the awareness of risk, minimizes the perception of pain and danger, and may be demonstrating a conditioned dissociative response to external traumatic stimuli; in contrast, the schizophrenic's failure to assess danger is due to delusional thinking. The aggressive behaviors in DID give the appearance of being unprovoked, yet deliberate; amnesia for the behavior may reflect an abrupt switch from one alter to another; however, the aggressive behaviors in schizophrenia are reactions to paranoid or delusional thoughts. The attention and memory problems inherent in DID manifest by amnesia that is beyond ordinary forgetfulness, by a highly variable memory, by self-contradictory information giving the appearance of disorganization, by trance states and by an inconsistent inattentiveness; the attention and memory problems in schizophrenia manifest by disorganized thought processes and by delusional personal information.

Armstrong and Lowenstein (1990) describe the formidable challenges to psychological testing of adolescents with DDs that are congruent with Silberg's (1996) research in developing the DFP. The challenges are related to dissociative pathology as evidenced in internal dividedness, in chronic state changes, in passive influence experiences, in interference and overlap phenomenon between alter personality states, as well as in co presence phenomena that produce a shifting and disorganized clinical

picture. Perhaps these challenges are attributable not only to the fact that the literature on the psychological testing of children and adolescents with DDs is sparse but also to the difficulty inherent in diagnosing DID in children and adolescents.

The research on diagnostic criteria for dissociative pathology, the theoretical models, the testing instruments and the structured interviews to assess for dissociative pathology, the frameworks to organize dissociative pathology, and the guidelines to differential diagnosis of DID continue to fuel the 1988 debate, “Resolved that Multiple Personality is a True Disease Entity” presented at the American Psychiatric Association in Montreal, Canada. The proponents (Richard Kluft and David Spiegel) of DID and skeptics (Martin Orne and Fred Frankel) of DID failed to resolve the same issues of credibility of traumatic memory, research methodology problems, organizational and media influences, and legal concerns.

Professional organizational opinions. The American Psychological Association (APA) has no official policy statement on the controversies surrounding adult memories of childhood sexual abuse within the field of psychology, but the Association does report the findings of the six clinical psychologists and researchers appointed to the Working Group on Investigation of Memories of Childhood Abuse formed in 1993 to review the literature on trauma and memory making recommendations to professionals and to the public (APA, 1996). The decision of the APA (1996) to exclude terms such as “repressed

memories”, “recovered memories”, “false memories”, and “implanted memories” from this report was based on their belief that the emotional impact of these terms makes rational, scientific discussion improbable, yet these are the terms often used in the trauma and memory literature (Applebaum, Uyehara & Elin, 1997).

While the consensus addresses adult memories of childhood sexual abuse, the achieved consensus may be equally applicable to children and adolescents who often present denying even corroborated sexual abuse events (Lewis, 1996; Steinberg, 1996) despite the proximity in time of the abusive events. The APA (1996) consensus conclusions are:

- 1.) Most people who were sexually abused as children remember all or part of what happened to them.
- 2.) Under certain circumstances, memories of abuse that have been forgotten for a long time can be remembered. The mechanism by which such delayed recall occurs is not currently well understood.
- 3.) Under certain circumstances it is possible to construct pseudo-memories. These are potentially harmful and disruptive to the person in whom they are induced as well as to his or her social support network.
- 4.) There are gaps in our knowledge about the processes that lead to accurate or inaccurate recollection of childhood sexual abuse.
- 5.) Future research is needed to provide a better understanding of the mechanisms by which accurate or inaccurate recollections might be identified.
- 6.) There are gaps in our knowledge of the most effective clinical approaches for avoiding creation of pseudo-memories and for enhancing the conditions under which actual events of childhood sexual abuse can be remembered.
- 7.) Given the present state of our understanding, there is no method, absent corroborative evidence, for determining absolute differences between actual and pseudo-memories (p.1,2).

The report by the APA's Working Group on Investigation of Memories of Childhood Abuse in 1993 does not include the list of articles reviewed by the group. However, a comprehensive discussion of the research findings related to the debate about the veracity of memories related to childhood sexual and physical abuse can be found in "Trauma and memory: Clinical and legal controversies" (Appelbaum, Uyehara, & Elin, 1997).

Psychological research via the Internet. The use of the Internet for research and practice purposes in the field of psychology is rapidly evolving. Recognizing the Web-based revolution for both scientists and practitioners in psychology, the Ethics Committee of the APA (1997) acknowledged that the Ethics Code is "not specific with regard to telephone therapy or teleconferencing or any electronically provided services and has no rules prohibiting such services." Although consideration to future revisions of the Ethics Code may allow for more definitive criteria, the Ethics Committee of the APA (1997) currently recommends that psychologists contemplating delivering services via telephone, teleconferencing, or Internet "review the characteristics of the services...and the provisions for confidentiality" as well as adhering to Standard 1.04c, Boundaries of Competence, "...take reasonable steps to ensure competence of their work and to protect patients, clients, students, research participants, and others from harm." Although one of the most rapidly growing procedures in psychological experimentation is that of

collecting empirical data over the Internet (Burdenski, 2001), one must consider not only the advantages but also the disadvantages of Internet data collection.

Internet advantages and disadvantages. Burdenski (2001) notes that the use of the Internet to collect data is an advantage in: (1) generating large heterogeneous samples; (2) opportunities to conduct cross-cultural research without travel expenses; (3) automatic coding and construction of data; (4) reduction in needed support staff; and (5) improved standardization of experimenter effects. Nevertheless, Burdenski (2001) cautions that there are ethical and legal concerns to consider, such as: (1) involving international participants means that researchers need to be cognizant that cultural and political factors may affect the participants responses; (2) cyberspace can mislead researchers about geographical location, gender, race, and age; (3) the economic and racial gap between users and nonusers of the Internet raises issues about representative samples; (4) obtaining informed consent; and (5) the lack of definitive guidelines from the APA Ethics Code Revision Task Force due to the rapid evolution of the use of the Internet by both scientists and practitioners.

Reips (2000) summarizes methodological advantages and disadvantages of using the Web for research. The advantages relevant to this study are: (1) ease of access to large numbers of participants; (2) ease of access to a specific population; (3) avoidance of time constraints for participants; (4) completely voluntary participation;

(5) reduction of demand characteristics; (6) cost savings of administration; and (7) public control of ethical standards. The disadvantages relevant to this study are: (1) possible multiple submissions; (2) a high dropout rate due to no financial consideration; (3) the absence of interaction between researcher and participants when instructions are misunderstood; and (4) external validity is limited due to dependence on computers and networks.

Solutions to methodological disadvantages. The use of APA membership e-mail addresses that will be described in the procedures section of the methods chapter is a common solution to maintain data integrity by identifying multiple submissions. Musch and Reips (2000) also cite other procedures to maintain data integrity such as asking respondents to participate only once, to use Cookies. Financial consideration for participation is not considered an option since this study addresses professionals who hopefully understand the seriousness of research as well as the need to obtain data based on scientific methodology. The instructions for this survey will be reviewed by four professionals for clarity of instructions before e-mailing the survey to prospective participants. There will be beta testing of the site for errors prior to posting the survey officially, to determine that the survey is comprehensible and readable for participants who will be using a variety of computers and to insure that the site is properly collecting data.

A concern prevalent on the WWW is that hackers are attempting to gain control over the Web server (Schmidt, 1997). However, Musch and Reips (2000) respondents report presently there is no evidence of hackers sabotaging psychological experiments on the Internet. The equivalency of response rates for the traditional method of mailing surveys versus the response rates of electronic surveys has been explored. Studies (Mehta & Sivadas, 1995; Weible & Wallace, 1998) found equivalency of response rates for both methods. The mean and range on Likert scale responses are equivalent for both survey methods (Kiesler & Sproull, 1986; Mehta & Sivadas, 1995). Despite the astounding equivalency between these data collection methods, some differences have been found. Electronic participants wrote more, and the writing was more complex (Mehta & Sivadas, 1995) than the paper and pencil method when answering open-ended questions.

Ethical issues for Internet use. The differences in ethical considerations between paper and pencil traditional survey methods and Web-based survey methods, surrounding informed consent, anonymity and confidentiality as well as the assurance to subjects that they can quit at any time have been explored by other researchers (Mueller, Jacobsen, & Schwarzer 2000). The National Institute of Mental Health (2000) conference on ethical considerations in mental health addressed issues of informed consent, privacy, role conflict, dealing with emergencies, institutional review boards, and technology issues. Conference attendants noted that the use of the Internet should not be held to higher

standards than current research procedures and reached agreement on procedures for minimizing risk for each issue under discussion. In keeping with the NIMH recommendations, the issues of anonymity, confidentiality, and voluntary cessation at any time will be briefly described to the subjects in the posting for the survey per se as presented in the procedure section of this study. The issue of informed consent for Internet surveys differs from the more traditional mail survey method: mail surveys have no formal consent form but rather have a letter introducing the subject to the research topic as well as to the researcher, and the return of the survey by the subject is considered to be consent. On the other hand, Internet research does not allow for obtaining the subjects' signature. Hence, the guidelines for consent described by other Web researchers such as utilizing the initial page of the survey as a consent form (Mueller, 1997; Smith & Leigh, 1997), and the commonplace practice in the real world of clicking on "agree" or "accept" buttons will be considered as the participant's consent to participate in this study.

Hypotheses

1. Psychologists who treat children and adolescents will demonstrate skepticism about DID on the Skepticism Scale, using a cutoff score of 33.

2. There will be an inverse relationship between professional skepticism about DID on the Skepticism Scale and professional knowledge about DID on the Knowledge Scale among psychologists who treat children and adolescents.
3. As the years of experience in psychology increase, psychologists' scores indicative of skepticism about DID in children and in adolescents will increase.
4. As the years of experience in psychology increase, psychologists' scores indicative of knowledge about DID in children and in adolescents will decrease.
5. Membership in the International Society for the Study of Dissociation (ISSD) and in the International Society for Traumatic Stress Studies (ISTSS) will demonstrate a negative correlation with items indicative of skepticism about DID in children and in adolescents and will demonstrate a positive correlation with items indicative of knowledge about DID in children and in adolescents.

Method

Participants

Soliciting participant recruitment for Web based research from lists related to the subject matter is a common technique that improves the validity of the study (Buchanan & Smith, 1999). Thus, a convenience sample of child and adolescent psychologists was recruited via the Internet using the 2000 and 2003 membership lists for the Society of Clinical Child and Adolescent Psychology Division 53 of the American Psychological Association (APA, 2000; APA, 2003).

There are 1,512 Division 53 members listed in the American Psychological Association's Directory for 2000 and 2003 (APA, 2000; APA 2003) with e-mail addresses. Initially, only those members with e-mail addresses (N=723) listed in the 2000 Membership Registry (APA, 2000) were recruited as potential participants. However, the large number of mailer daemons (160), combined with a low return rate (N=1), a week after the initial e-mailing indicated that the pool for potential participants needed to be revised to increase the potential return rate. Therefore, a request was sent to the IRB and approved by the IRB to include members from the more updated on-line 2003 Division 53 membership (APA, 2003).

A separate Website server was utilized and monitored by a research assistant to ensure anonymous participation and to provide an on-line data file accessible only to the

researcher who knew the account password. The cross-sectional design included the following characteristics of psychologists who treat children and adolescents: gender, age, highest degree obtained, race, years of experience in field of psychology, number of seminars/conferences attended related to DID, primary work setting, job title, theoretical orientation, number of children assessed in a year, number of adolescents assessed in a year, years of experience in the field, and professional organization membership.

Overview of the Research Design

This survey used a cross-sectional design to investigate the presence or absence of skepticism about DID and the knowledge about DID which correlates with the accurate diagnose of DID in an adolescent by psychologists who treat children and adolescents.

Measures

The instrument to study the accuracy of diagnosis, knowledge and skepticism of psychologists who treat children and adolescents consisted of three parts: (a) Part 1 entailed completing the diagnosis on two vignettes, (b) Part 2 queried items related to skepticism and knowledge about DID and Schizophrenia, and (c) Part 3 entailed completing demographic information. Participants were requested to respond to each of the vignettes prior to answering questions cited in Part 2 of the survey.

Case vignettes. The case vignettes were created in accordance with the DSM-IV TR criteria of symptomatology and essential features of DID. Across the vignettes,

factors that were not integral to the diagnosis were held constant. For example, since DID is more commonly diagnosed in females than in males, the DID adolescent was female. The credibility of the vignettes was established by Hayes and Mitchell's (1994) research involving therapists' skepticism about MPD in adult patients. Since there were changes (age of patient, occupation to student status) made in the vignettes, an independent review to ascertain the usability of the revised vignettes for this study was completed by Richard Kluft, MD, a professional experienced in diagnosing DID and schizophrenia in adolescents.

Scoring for the vignettes was as follows. For an inaccurate diagnosis, a score of 0 was assigned. For an accurate diagnosis of DID, a score of 1 was assigned. Respondents provided diagnoses in an open-ended manner as opposed to selecting from a list.

Skepticism and knowledge survey. The survey instrument that was to be completed after a diagnosis was given for each of the vignettes consisted of 17 rationally derived items designed by Hayes and Mitchell (1994) to measure skepticism and knowledge about DID. Participants were asked to indicate their agreement using a 5-point Likert scale, (1) strongly disagree, (2) disagree, (3) unsure, (4) agree, and (5) strongly agree. Of the total 30 survey items: 11 items measured skepticism about DID; 6 items measured knowledge about DID; the remaining 13 items were to distract from the focus on DID.

The survey instrument has a Cronbach's alpha of .85 and an unequal Spearman-Brown split-half reliability coefficient of .84 for the Skepticism Scale and a Cronbach's alpha of .52 for the Knowledge Scale (Hayes & Mitchell, 1994). The researchers established construct validity for the Knowledge Scale using the contrasted groups method, which involved undergraduate students and mental health professionals.

Demographics. Demographic characteristics (age, gender, race/ethnicity, years of postgraduate experience in the field, highest degree obtained, and professional organization membership) were included in Part 3.

Procedures

The 1,512 Division 53 members listed for 2000 and 2003 (APA, 2000; APA, 2003) with e-mail addresses were recruited via the Internet for participation in this research, using Perseus software. Perseus software was selected because of the software's ability to allow individual participants to click into links, because of its branching capacity, and its ability to follow-up with a second request for participation to those who had not responded within two weeks. A research assistant prepared a spreadsheet with potential participants e-mail addresses for transfer to the computer software to ensure confidentiality. The Web site had a password and identification number for data access that was known and accessible only to the researcher; this is equivalent to a locked box used for postal mail surveys.

Four professionals reviewed and responded to the survey for clarity of instructions and of content before the survey was e-mailed to prospective respondents. There was testing of the Web site, by a research assistant, to determine that there were no program errors prior to officially e-mailing the data; to ensure that the survey was comprehensible and readable for participants who used a variety of computers; and to ensure that the independent Web site was functioning properly to collect the data.

Despite these precautions to prevent technical problems for respondents, technical issues arose. For example, AOL does not allow for bulk e-mailing, assuming that this is indicative of sending out SPAM. Thus, the research assistant sent the e-mails in small groups. Nevertheless, AOL took measures to block e-mailing from the Web site, still believing that the large numbers of e-mails indicated SPAM. This issue was resolved within 24 hours via contacting AOL and explaining the nature of the bulk mailing, thus enabling the site to have the blocks removed.

Informed consent was obtained by staging the survey so that the initial page was an information and consent page rather than part of the survey proper. Since it was not feasible to obtain the participant's signature, the participants were presented with an on-screen button to click, thus accepting the terms of the consent form prior to proceeding to the actual survey. Since prospective participants were free to delete the e-mail, voluntary participation was assured.

An Excel Program spreadsheet was used to organize and sort the data collected by APA member respondents. A research assistant reviewed the spreadsheet data in order to: screen for multiple submissions; to delete any identifying data such as IP headers, e-mail addresses, or members' names to ensure confidentiality; and to transfer the data via computer from the Excel Program spreadsheet to the SPSS program for statistical analysis. The use of a cookie prevented multiple submissions from respondents. Feedback was given by means of a closing page to: to acknowledge submission, to thank the respondent, to provide contact information for the researcher, and to advise participants of the date and length of time that the results of the survey were posted on the Web server.

Results

Participants and Demographics

Of the 1512 surveys e-mailed to 2000 and 2003 members of the American Psychological Association Division 53 (APA, 2000; APA 2003), 269 (17.7%) were invalid email addresses leaving a total of 1243 (82%) as valid e-mail addresses. Of the useable addresses, 1146 (92.2%) of the potential participants did not respond to the survey, despite a second e-mail request to participate; 34 (2.7%) of the participant pool completed the survey. Of the total number of potential subjects (1146), 21 (1.8%) responded that they did not want to participate, citing reasons such as they did not treat adolescents or they were in education or in government work; 19 (1.5%) sent an auto response; 19 (1.5%) reported technical problems; 12 (1%) responded with a query such as a request for a reminder sent closer to the final date of data collection; and the remaining 7 (.5%) responses were categorized as miscellaneous such as requests that the survey be sent via postal service.

The respondents were predominately white (97.1%), female (52.9%), and between 30 and 49 years of age (70.6%). All respondents had doctoral degrees (PhD, 85.3%; PsyD, 14.7%). The majority of respondents practiced psychology from 1 to 19 years (64.8%). The primary work settings were identified as private practice (41.2%) and

University/College Academic positions (26.5%) with the predominately cited job title of clinical psychologist (85.3%).

Skepticism, Knowledge, and Demographic Correlations.

The correlation analyses were limited by the small sample size. Thus, the results of this study are primarily descriptive. As predicted, the hypothesis that the Skepticism and the Knowledge variables would have a negative correlation was supported but was not statistically significant (see Table 1). Both the Skepticism and Knowledge variables were used for correlation analyses with the following demographic variables: age, organizational membership, gender, highest degree obtained, number of children 1-12 years old assessed in a year, number of adolescents 13-18 years old assessed in a year, race/ethnicity, seminars related to DID which had been attended, and years of practice. The results of these correlation analyses are presented in Table 1. There was a statistically significant relationship between the Skepticism variable and highest level of education obtained. There was also a statistically significant relationship between the Skepticism variable and race/ethnicity. There was also a statistically significant relationship between the Knowledge variable and the attendance at seminars related to DID.

Table 1

Correlation Coefficients for Skepticism, Knowledge, and Demographic Variables

Variables	Skepticism Scale		Knowledge Scale	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Skepticism Scale	-	-	-.24	.09
Knowledge Scale	-.24	.09	-	-
Age	-.05	.79	.12	.50
American Psychological Association ^a	.01	.97	-.04	.81
American Psychological Society ^{a,b}	-.03	.88	.05	.79
Gender ^a	.10	.57	.06	.74
Highest level education	-.35*	.04	.32	.07
No children 1-12 y.o. assessed	.18	.31	-.09	.61
No adolescents 13-18 y.o. assessed	-.09	.62	.19	.28
Race/ethnicity	.42*	.01	-.17	.35
Seminars attended re: DID	-.06	.72	.35*	.05
Years Practicing Psychology	.14	.42	-.02	.92

Note. $N = 34$. ^a Due to the dichotomous nature of this variable, the correlation coefficient and p -value reported in this table were calculated using a point-biserial correlation (r_{pb}). ^b

$n = 21$. * $p < .05$.

Misdiagnoses

Case Vignettes. Results demonstrated that DID was misdiagnosed with a greater frequency than schizophrenia (see Table 2). For the DID vignette, the other diagnoses (70.7%) were: acute stress disorder (2.9%), adjustment reaction disorder (2.9%), amnesia due to... (2.9%), bipolar disorder (2.9%), depressive disorder (11.8%), dissociative amnesia (11.7), dissociative disorder (5.8%), depersonalization disorder (5.8%), posttraumatic stress disorder (11.7%), and schizoaffective disorder (2.9%). For the schizophrenia vignette, other alternate diagnoses (58.8%) were: adjustment disorder (2.9%), bipolar disorder (2.9%), depressive disorder (14.7%), psychotic disorders (17.6%), schizoaffective (2.9%), and schizophreniform (8.8%). On both the DID and schizophrenia vignettes, two respondents noted that there was insufficient information (5.8%) to make a primary diagnosis and one respondent deferred (2.9%) to cite a primary diagnosis.

Table 2

Percentages for Frequency of Diagnostic Accuracy for Dissociative Identity Disorder (DID) and Schizophrenia Case Vignettes

Diagnosis	DID vignette	Schizophrenia vignette
	(<i>N</i> =34)	(<i>N</i> =34)
	<i>f</i> %	<i>f</i> %
Dissociative Identity Disorder	17.6	-
Schizophrenia	2.9	41.2
Dissociative Disorder NOS	8.8	-
Other	70.7	58.8

Note. Cells with a dash indicate no reported data obtained.

Degrees of Skepticism about DID

The hypothesis that psychologists who treat children and adolescents would demonstrate the presence of Skepticism about DID on the Skepticism Scale, scoring at or above the cutoff of 33 was not supported. Moderate to extreme skepticism about DID was reflected by scores greater than or equal to the theoretical midpoint of 33 on the Skepticism Scale. Five respondents (14.7%) scored greater than or equal to 33 on the Skepticism Scale, indicating moderate to extreme skepticism about DID. Twenty nine

respondents (85.2%) scored less than 33 on the Skepticism Scale, indicating a lesser degree of skepticism or an absence of skepticism about DID.

The range for the Skepticism Scale scores was 20 - 37 ($M = 29.76$, $SD = 4.55$). The frequency percentages for the Skepticism Scale items for strongly disagree and disagree, as well as strongly agree and agree, have been consolidated and are presented in Table 3.

Psychologists' Knowledge about DID

The hypothesis that psychologists who treat children and adolescents and who demonstrated the presence of skepticism about DID on the Skepticism Scale would have low scores on the Knowledge Scale about DID was not supported. The range for the Knowledge Scale scores was 15 - 23 ($M = 19.05$, $SD = 2.05$). The frequency percentages of the Knowledge Scale items have been condensed and are presented in Table 4.

Experience in Psychology, Skepticism Levels, and Knowledge Scores

The hypotheses that psychologists with increased years of experience in psychology would demonstrate the presence of skepticism about DID on the Skepticism Scale scoring at or above the cutoff of 33 and would demonstrate a decreased knowledge about DID on the Knowledge Scale were not supported. Of the total sample, 29 (85.3%) respondents had attended at least one seminar over the past five years during which they learned about DID; however, 11(32.3%) respondents had attended more than one

seminar. The number of children between the ages of 1 and 13 assessed in a year had a mean of 42.11. The number of adolescents between the ages of 13 and 18 assessed in a year had a mean of 33.79.

ISSD, ISTSS Membership and Impact on Skepticism and Knowledge Scores

The hypothesis that members of the ISSD and the ISTSS would demonstrate an absence of skepticism about DID and would demonstrate knowledge about DID was not supported due to lack of reported membership numbers. No participants were members of the ISSD and only one participant was a member of the ISTSS. The respondents' reported theoretical orientations varied: 12 (35.3%) respondents had no psychodynamic orientations, although 5 (14.7%) respondents used it 20% of the time. Eight (23.5%) respondents had a 50% learning orientation, yet 3 (8.8%) respondents had a 100% learning orientation. Ten (29.4%) respondents had no humanistic orientation, but 6 (17.6%) respondents had a 20% orientation, and 21 (81.8%) respondents reported other orientations. The other orientations utilized are presented in Table 5 and the time percentage usage for these orientations ranges from 10% to 50%.

Table 3

Frequency Percentages for Skepticism Scale Items

Skepticism Scale Items	Strongly Disagree/Disagree	Strongly Agree/Agree
	(<i>N</i> = 34) <i>f</i> %	(<i>N</i> = 34) <i>f</i> %
The existence of DID as a clinical phenomenon has been demonstrated beyond any reasonable doubt.	38.2	38.3
DID is under-diagnosed.	47.1	14.7
DID can be created in counseling/psychotherapy.	26.4	58.9
DID is a misdiagnosis of schizophrenia.	70.6	8.8
More funding should be devoted to research on DID.	23.5	58.8
DID is largely an excuse used	82.4	17.6

Skepticism Scale Items	Strongly Disagree/Disagree	Strongly Agree/Agree
	<i>(N = 34)</i>	<i>(N = 34)</i>
	<i>f%</i>	<i>f%</i>
to avoid responsibility for personal actions.		
DID is extremely rare.	26.5	58.8
People can fake DID successfully.	29.4	52.9
All of the symptoms related to DID can be explained by and accurately diagnosed as another psychological factor.	64.7	11.7
DID does not exist.	79.4	8.8
I would not diagnose someone as having DID.	61.8	17.5

Table 4

Frequency Percentages for Knowledge Scale Items

Knowledge Items	Strongly Disagree/Disagree	Strongly Agree/Agree
	(<i>N</i> = 34) <i>f</i> %	(<i>N</i> = 34) <i>f</i> %
Major trauma is a contributing factor to developing DID.	11.8	79.5
The number of documented DID cases has increased over the past two decades	14.7	50.0
DID is an Axis II disorder	72.5	-
PTSD is classified as a dissociative disorder in the DSM.	64.7	14.7
DID has been diagnosed more frequently in females than males .	2.9	85.3

The onset of DID is invariably 17.6 47.0
in childhood.

Note. Cell with a dash indicates no data obtained.

Table 5

Frequency Percentages of Other Theoretical Orientations

Other Theoretical Orientations	(<i>n</i> = 13)
	<i>f</i> %
Contextual-based	2.9
Biological / Neurological and Attachment	2.9
Biopsychosocial	2.9
Construct Psychology	2.9
Constructivist	2.9
Family Systems	5.8
Family / Ecological Systems	2.9
Integrative	2.9
Integrative / Developmental	2.9
ISTSS	2.9
Relational Family Systems	2.9
Systemic	2.9

Discussion

The results of this study presented the statistical analyses related to psychologists' skepticism and knowledge about DID in diagnosing adolescents, using case vignettes and Skepticism and Knowledge Scales. This chapter will explore the implications of these findings and offer reflections about the low response rate, about case vignettes, and about Skepticism and Knowledge Scales for the paradigmatic dissociative disorder, DID.

Considerations about Participants' Response Rate

Since the literature related to Internet research indicated that there is no difference in response rates between traditional survey methods (postal mailing) versus Internet surveys (Birnbaum, 2000), the extremely low response rates to the initial and second requests for participation in the present study were astonishing. The recent dramatic increase in SPAM, the Internet equivalent of the telemarketer, could play a role in the potential subjects deleting the two e-mail invitations to participate in this study prior to reading the survey per se. Clues that some potential participants did not read the survey are evident in e-mails to the researcher from potential participants. For example, a potential participant reported that she participated only in IRB approved surveys. Since the Website hosting the Internet survey included an extensive informed consent form citing IRB approval, as well as information to directly contact the IRB Chairperson, one can assume this individual never reviewed the Website.

citing IRB approval, as well as information to directly contact the IRB Chairperson, one can assume this individual never reviewed the Website.

Keeping in mind that those who did send e-mails to the researcher may or may not have been included in the actual returned surveys, other potential participants' e-mails provided further issues related to response rate; these bear consideration. Technical problems with certain browsers may have been unknown to the researcher, although some participants sent e-mails advising of technical problems that were easily solvable. The live testing of the Website with feedback from four professionals did not indicate technical concerns. Others, who had obviously read the Website survey, chose to e-mail messages that their self-perceptions indicated a lack of competency in diagnosing adolescents; that they worked only with prepubescent children, and/or their work areas excluded them from participation. Although most reported private practice as their primary work setting, others reported University/College Academic settings; the survey was up on the Website during April and May which are busy times for academicians in the throes of ending the scholastic semester.

Despite all these possible rationales for low rate of return, it is difficult to believe that the 92.2% who did not respond to the survey fit into the above categories. This study's low response rate is consistent with Kluff's (1990) findings that scientific formats reluctantly address topics relevant to diagnosing DID. One could speculate that the topic

of the survey, Skepticism and Knowledge about DID, may be more reflective of the abysmal response rate than to any other consideration. Other researchers (Dunn, et al., 1994), experiencing similar low response rates about professional skepticism and DID, have also suggested that those who chose not to respond may be more skeptical of DID than those who did respond.

This must be especially true if one notes that the majority of those who did respond to this survey were well educated and were knowledgeable about DID, having attended at least one, if not many, seminars about the topic of DID within the previous past five years. The rate of seminar/conference attendance was surprising, in light of the fact that a major conference about DID in children and adolescents hosted by Sheppherd and Enoch Pratt Institute in Baltimore, Maryland, a facility which has a specialty unit geared to assessing and treating DID in children and adolescents, was cancelled due to extremely poor registration within the previous past five years.

Misdiagnoses of DID

Case Vignettes. It is noteworthy that although survey participants indicated an absence of skepticism and were knowledgeable about DID, only a small percentage of respondents (17.6%) accurately diagnosed the DID vignette. It is ironic that 47.1% of participants for this survey strongly disagreed/disagreed that DID is under diagnosed, while almost twice as many respondents (82.4%) for this survey provided various false

negative diagnoses. These false negative diagnoses, from a majority of the sample, have unwittingly only added to the number of under diagnosed DID cases. It is a paradox that the DID vignette in this study was under diagnosed by the very participants who disagreed that DID is under diagnosed.

This finding is congruent with dissociative experts' findings that DID is one of the most difficult mental disorders to diagnose (Kluft, 1991; Peterson, 1996; Putnam, 1991). Some respondents did recognize the features of a dissociative pathology (DDNOS, 8.8%; DD, 5.8%; Dissociative Amnesia 11.7%; Depersonalization Disorder, 5.8%; and PTSD, 11.7%), in the DID vignette, lending credence to dissociative experts' consistent findings that DID, the paradigmatic DD, is not often diagnosed in childhood and adolescents (Peterson, 1996; Putnam, 1991).

Unlike prior research findings (Hayes & Mitchell, 1994; Ross & Norton, 1988) in the dissociative adult literature, in which DID is often misdiagnosed as schizophrenia, most respondents (70.6%) disagreed that DID is a misdiagnosis of schizophrenia. Only one participant diagnosed schizophrenia for the DID vignette; none reported DID for the schizophrenia vignette.

One begins to speculate that there is a gap that has yet to be identified between the acquired knowledge about this group of mental health disorders and the actual operationalization of this knowledge in clinical areas. Perhaps this is related to the

polymorphous symptom presentation inherent in DID (Lewis, 1996; Steinberg, 1996). It is possible that this unidentified gap could be a contributing factor to the lengthy period of time between mental health assessment when symptoms indicative of DID are present in the patient and when the accurate diagnosis of DID is made by professionals (Putnam, et al., 1989). The gap between acquired knowledge about mental health disorders and operationalized knowledge in the clinical area becomes even more relevant when considering the fact that the schizophrenia vignette had less than 50% accuracy for diagnosis, with 17.6% of the participants diagnosing this vignette as a psychotic disorder. Berenson's (1998) belief that the trend in clinical training emphasizing strict adherence to the DSM-IV-TR criteria, rather than amplifying diagnostic considerations through the exploration of development, the assessment of risk factors, and the description of family dynamics, contributes to missed diagnoses for adolescents, and this warrants further consideration to resolve diagnostic dilemmas.

Certainly, the diagnostic results for the DID vignette denote the fact that although the diagnostic criteria and nomenclature for DID have been changed since it was first included in the DSM III as a separate diagnostic entity in 1980, these changes have not enabled practitioners to diagnose the disorder more accurately when given clinical data that experts in DID concur is indicative of the DID diagnosis. These results support Dell (2001) and Peterson's (1999) ongoing, although unsuccessful, advocacy for revisions in

DSM criterion that will enable clinicians to have access to a set of criteria more specific to DID, especially for children and adolescents. Perhaps other revisions in the learning materials (handouts, videotapes) used in seminars and conferences are also needed to portray the differences in dissociative diagnoses more accurately when features of dissociative pathology are being presented.

Skepticism and Knowledge Scales. These survey results indicated a lack of skepticism about DID as well as a presence of knowledge about DID. However, a Skepticism Scale item demonstrated an obvious, almost equivalent, divisiveness in responses related to the existence of DID as a clinical phenomenon, which is being demonstrated beyond any reasonable doubt. Reminiscent of Ellenberger's (1970) extensive historical review of the two-hundred years old debates related to dissociative pathology, some respondents (38.2%) strongly disagreed/disagreed that the existence of DID was beyond any reasonable doubt; other respondents (38.3%) strongly agreed/agreed.

This divisiveness leads one to speculate about the data necessary for a more cohesive view of this belief within the field of psychology. This .1% difference could exemplify the influence on psychologists of the contemporary scientific discourse, in the trauma literature, between advocates of DID (Kluft, 1997; van der Kolk, 1997) and skeptics of DID (Hyman & Loftus, 1997). Proponents of DID and skeptics of DID each

accuse the other side of faulty research methodology as well as over generalized conclusions. This further confounds and complicates the issues relevant to trauma sequelae (Appelbaum, Uyhara, & Elin, 1997).

The results of the Skepticism and Knowledge Scales present some puzzling information. For example, there was predominant agreement (79.5%), within this sample, that trauma in childhood contributes to developing DID and that the onset of DID is invariably in childhood (47%). This finding is consistent with research reports in the dissociative literature that DID develops prior to six years of age (Kluft, 1984; Peterson, 1996; Putnam, 1997; Ross, 1997), and with developmental experts' findings (Macfie, Cicchetti, & Toth, 2001) that physically and sexually abused pre-school children demonstrate more dissociation than nonmaltreated children, following different dissociative trajectories.

The majority of respondents' (58.9%) belief that DID can be created in counseling/psychotherapy is consistent with the views of skeptics of DID (Lief, 1994; Loftus, 1993; Hyman & Loftus, 1997; Spanos, 1994). Skeptics of DID have concluded that false memories of abuse, and DID, can be iatrogenically created by therapists. Skeptics of DID believe that therapists who suggest therapeutic activities to patients such as hypnosis, sodium amytal, imagery techniques, journaling, and reviewing old family photographs can lead the patient to construct memories of events that never occurred

(Hyman & Loftus, 1997). Such bewildering information not only creates double binds, but also raises questions for the psychology practitioner.

The double bind exists if the psychologist leans towards the trauma-based model, diagnosing DID; the possibility then exists that the psychology practitioner may be accused legally and professionally of iatrogenically creating the disorder via therapeutic suggestions. On the other hand, if one leans towards the sociocognitive model, not diagnosing DID when it is present, then the possibility exists that the psychology practitioner can be held legally responsible for misdiagnosing a disorder that has been established as trauma-based and is cited in the DSM. Congruent with the results of this study, one can only speculate that DID would not be the primary diagnosis considered even when the clinically presented material meets DSM criteria for DID. Perhaps the 61.8% of participants who disagreed with the idea that they would not diagnose someone as having DID suggests that DSM criteria needs to reflect more accurately the clinical presentation of this patient population to avoid misdiagnosis.

The following question arises: if the onset of DID occurs in childhood, prior to six years of age, why are so few patients with DID not diagnosed as having DID until they are twenty or thirty years of age (Horevitz & Braun, 1986; Kluft, 1985; Putnam, et al., 1986)? If it is true that DID can be created in counseling/psychotherapy, is it not possible to dissimulate evidence of DID in counseling/psychotherapy? A large percentage (58.8%)

agreed that DID is extremely rare. Is it possible that it is rare because it is seldom diagnosed accurately, as the results of this and other studies indicate? One could wonder if there is truth in the proverb that one cannot diagnose what one does not know exists (or considers to be rare). Yet in this sample, 79.4% strongly disagreed/disagreed that DID does not exist.

The following Knowledge Scale items are indicative of the knowledge about DID that have possibly been acquired at the numerous seminars/conferences attended by these participants. These items further support the view that there is a gap between acquired knowledge and operationalizing the acquired knowledge in clinical areas. The majority of participants (72.5%) demonstrated knowledge that DID is not an Axis II disorder. Most respondents (85.3%) indicated being knowledgeable about the findings that DID has been diagnosed more frequently in females than in males (APA, 2000). The current gender ratio (9:1) for DID, based on adult populations, may shift in the future as findings in small samples for gender ratios in children and in adolescents diagnosed with DID have been found to be closer to 1:1 (Waterbury, 1991).

Other participants (64.7%) recognized that PTSD is not classified as a dissociative disorder in the DSM, despite the overlapping symptomatology between PTSD and DID. Given this knowledge base about DSM classifications, it is curious that 11.7% of participants did diagnose the DID vignette as PTSD, which is classified as an

anxiety disorder. A review of the overlapping symptomatology of PTSD and DID succinctly described in Nemzer's (1996) behaviorally based guide to differential diagnosis could give more clarity to distinguishing between PTSD and DID in clinical practice. Adult DID patients have reported PTSD as a diagnosis preceding the diagnosis of DID, supporting Berenson's (1998) belief that "one disorder may be an early manifestation of another disorder or that one disorder may be part of another (p. 918)" as many DID patients also meet criteria for PTSD. Nevertheless, dissociative experts (Putnam, 1997; Ross, 1997) recommend that the DID diagnosis is super ordinate to the PTSD diagnosis when patients meet criteria for both, as clinically the DID diagnosis subsumes the PTSD symptomatology.

The majority of participants' (58.8%) agreement that more funding should be devoted to research on DID might also consider allocating a portion of these funds to an empirical study of how psychologists operationalize acquired knowledge about DID in clinical practice. Ross (1989) notes that graduate training about DID is rarely mentioned and trainees are often told that DID is over diagnosed and rarely encountered. Nevertheless, 50% of participants in this study recognized that the number of documented DID cases has increased over the past two decades. Proponents of DID (Ross, 1997), attribute the increase in diagnosed cases to recently developed dissociative

testing procedures and diagnostic skills. However, skeptics of DID (Lief, 1994) attribute the recent increase in reported cases of DID to the iatrogenic nature of DID.

Lief (1994), a member of the False Memory Syndrome Advisory Board, reported that in more than fifty years as a practicing psychiatrist, he has never encountered a case of DID. Apparently beliefs about the rarity of DID, rather than knowledge about DID, may have influenced the participants' selection of a diagnosis, albeit inaccurate, for the DID vignette. To extrapolate from Navajits' (1997) work, practitioners base their therapy on theoretical models created from beliefs and private assumptions.

Whether one espouses trauma-based beliefs or sociocognitive beliefs, the truth is that both are fallible. It is possible that the inaccurate diagnoses for the DID vignette were based more on private assumptions than on knowledge acquired. The acrimonious nature of the debate between proponents of DID and skeptics of DID leads one to contemplate Ross' (1997) belief that between proponents of DID and skeptics of DID is an "ideology and bias, not because of data or science...but because of the link between DID and childhood physical and sexual abuse (pp, 70, 80)." Perhaps this reflects Rivera's (1996) belief that there is a societal denial about the physical and sexual harm done to children by parents, and that the harm done in childhood can have traumatic sequelae.

A majority (64.7%) of participants strongly disagreed/disagreed that all of the symptoms related to DID can be explained by and accurately diagnosed as another

psychological factor. Paradoxically, 70.7% of the sample did, indeed, diagnose the DID vignette as another psychological diagnosis. This lends credibility to other researchers' (Hornstein, 1996; Putnam, 1997; Steinberg, 1996) findings that the complex symptom presentation of DID requires clinicians to develop a framework to organize the complex symptom presentation and to request diagnostic consultation with DID experts.

The large percentage (82.4%) of participants who strongly disagreed/disagreed that DID is largely an excuse used to avoid responsibility for personal actions was a surprise. Conversely, 52.9% of participants reported that people can fake DID successfully. This suggests that another paradoxical belief set exists within this sample.

Assuming a factitious posture of DID suggests that there is a benefit to faking DID. Usually the benefit of faking a factitious pathway in any mental disorder is to avoid legal responsibility for one's actions as in the highly sensationalized case of Kenneth Bianchi, the Hillside Strangler (Watkins, 1984). Media presentations of DID often illustrate a dramatic, over sensationalized individual accused of heinous crimes, such as the main character in the recent movie, *Primal Fear*. The characters portrayed in films and soap operas depict alternate self-states who assume executive control of the individual and often, in the film, do escape responsibility for their illegal actions by feigning DID.

Lewis' et al. (1996) extensive research findings about the objective documentation of 12 convicted murderers who have DID refutes the media portrayals of DID. These researchers' findings were that all 12 murderers met the criteria for DID, but that not one of the 12 had used the diagnosis of DID as part of their legal defense. However, other researchers' (Spanos, Weekes, Menary, & Bertrand, 1986) findings suggest that features of DID can be simulated because college students were able to role-play successfully features of DID. Ross (1997) has countered the findings about simulating DID, although admitting that college students can easily role-play features of DID. He notes that the participants did not have specific primary and secondary features of DID and did not role-play anything approaching the full clinical picture of DID.

Spiegel (1993) summarizes the historical and contemporary waxing and waning of professional beliefs about DID that led to this study:

The phenomena of dissociation have themselves been dissociated from the mainstream of psychiatry and psychiatric theory despite origins at the heart of early psychiatric and psychological thought. William James, Morton Prince, Joseph Breuer, Sigmund Freud, and Pierre Janet based their diverse but influential theories of psychological functioning in large measure on their observations of dissociation and its effects. Despite this history, the phenomenon has been viewed as something of an oddity in psychiatry, causing many to doubt the validity of the disorders (p. ix).

Conclusions

Exploratory determinations. Unlike research findings on professional skepticism and knowledge about DID found in the adult literature, participants demonstrated a lack of skepticism about DID and were knowledgeable about DID. Nevertheless, the high percentage of false negative diagnoses for the DID vignette suggested a gap between the knowledge acquired about DID and application of the knowledge acquired to make an accurate diagnosis of DID. Because of the limitations of this study, the findings for this research can be considered only as exploratory rather than conclusive. Perhaps the real conclusions for this study lie in the data that has not been obtained because of the potential participants' reluctance to respond. It is possible that the data from those who chose not to participate could emulate the findings on professional skepticism about DID found in the adult literature reflecting not only extreme skepticism about DID, but also a lack of knowledge about DID

Tracking Woozles. In Milne's (1994) work, "The Complete Tales of Winnie-the-Pooh," Milne describes the experience of Pooh Bear tracking Woozles in the forest; that is a metaphor applicable to the conclusions for this study. In the story, Piglet spots Pooh walking in the forest and joins him, learning that Pooh is following tracks that he believes were made by a Woozle. As Pooh and Piglet continue walking in circles following the tracks, Piglet becomes frightened believing that perhaps there is more than one Woozle

and that they may be tracking Wizzles. He thinks about ways that he might leave Pooh to track alone, so that he might be “Out of All Danger Again” (p.40). When their friend, Christopher Robin, whistles from a tree branch, Piglet uses the opportunity to leave Pooh with Christopher, and he to run home.

Christopher points out to the little bear that he, Pooh, went round the spinney himself and then was joined by Piglet and they went round the spinney together. Pooh paused to think “in the most thoughtful way that he could think” (p.41) and becomes aware that the tracks were his own and Piglet’s, not the Wozzles. Meanwhile, Piglet who has left the scene, relieved to be out of danger, does not learn that the tracks were made, not by Wozzles, but by himself and Pooh.

Pooh represents participants in this study, and Piglet represents those who chose not to respond. Christopher Robin represents the existing body of knowledge related to DID found in the literature. Similar to the story line, both participants and non participants in this study have followed the tracks laid down by the proponents of DID and the skeptics of DID in the literature on dissociative pathology. Participants had to think about dissociative pathology, much like Pooh, in a most thoughtful way in responding to the survey. Non-participants, similar to Piglet, chose not to respond to the survey, perhaps believing that DID is not a credible diagnosis, missing, however, an opportunity to contribute valuable information about their beliefs to the field of

psychology. Perhaps, like Piglet, non-participants had an initial curiosity about the survey and began to feel threatened, believing themselves to be in professional danger should they respond to a survey on such a controversial diagnosis via the Internet. Such a belief is understandable, at a more personal level, as one considers that acknowledging DID implicitly acknowledges that childhood physical and sexual abuse exists, and that the abuse can have an enduring pattern of pathological sequelae, DID. The lack of definitive conclusions for this study points to the idea that the diagnostic tracks about DID laid down by clinicians diagnosing DID in adults have not been followed by clinicians who diagnose children and adolescents. Psychologists who diagnose children and adolescents seem to believe the tracks are Woozles rather than diagnostic criteria for DID, suggesting the existence of professional skepticism about DID, as well as the lack of knowledge about DID that researchers (Dell, 1988; Hayes & Mitchell, 1994) have found among therapists treating adult populations.

The limitations of this study, particularly the low response rate, lend some credence to Putnam's (1997) awareness that the field of dissociative pathology in childhood lags behind the dissociative pathology field related to adults. Psychologists diagnosing children and adolescents may continue tracking Woozles rather than thinking, similar to Pooh, in a most thoughtful way about the centuries-old literature and research findings about DID that is currently available to them.

Limitations of the Study

The primary limitation of this study was the extremely low response rate of 2.7% that allows only for a descriptive statistical analysis and reduced power in calculating correlations between variables. The low response rate and the low internal consistency of the Knowledge Scale hindered external validity. Generalizeability was prohibited also by the nature of the topic and the selected category of DID in children and adolescents. A final limitation was that the Skepticism and Knowledge Scales designed by Hayes and Mitchell (1994) had not been formerly used on a population of therapists treating children and adolescents because their study investigated the skepticism and knowledge of therapists about DID in adults.

Future Research Directions

Improving response rate. The abysmal response rate from potential participants for this study indicates a reluctance among psychologists to respond to topics relevant to diagnosing DID in children and in adolescents that is reminiscent of Kluff's (1990) findings that scientific committees are reluctant to present topics relevant to diagnosing DID. Future researchers might circumvent this issue by utilizing a pool of participants friendly to the researchers, as Hayes and Mitchell (1994) did in their research on professional skepticism about DID. For example, obtaining support for replicating this

research from administrators of agencies specializing in diagnosing and treating children could increase accountability for therapists to respond to the survey.

Replicating this study via more traditional research methods such as postal mail surveys could also expand the response rate. The recent explosion of SPAM on the Internet, potential participants changing online communication services, changes in e-mail addresses, and the plethora of browsers have been obstacles to conducting research via the Internet.

Skepticism about DID. The research findings about a positive correlation between trauma and dissociation involving children from preschool through late adolescence provides fertile ground for researching skepticism about DID. These findings indicate that maltreated children do not follow the normative dissociation trajectory found in cross sectional developmental studies: the older the child, the less dissociation (Macfie, et al., 2001). Future research could combine developmental researchers' expertise with trauma researches' expertise to determine the beliefs and the knowledge held by the clinicians about abnormal dissociative trajectories found in maltreated children. The results of this research could be useful in ascertaining why DID is seldom diagnosed in childhood.

Knowledge about DID. Dissociative experts (Ross, 1989; Silberg, 1998) concur that graduate programs seldom include training in dissociative pathology, or training in the use of psychological testing to ascertain dissociative pathology. Future research

focusing on the information necessary for inclusion in graduate programs relevant to assessing and treating dissociative pathology is required to determine how knowledge about DID is obtained, or not obtained. Another avenue for research is to survey graduate students about the knowledge obtained in their respective graduate programs when assessing maltreated children and adolescents for dissociative pathology. The findings from these proposed studies may lend support to the belief that one can not diagnose what one does not know exists.

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Appendix A

e-mail Invitation to Psychologists to Participate in Study

From: Nemadden@aol.com.

Subject: Doctoral Candidate Seeking Candidates for Research Study – Not SPAM

My name is Nancy Madden and I am a doctoral candidate in clinical psychology at Philadelphia College of Osteopathic Medicine. If you have already responded to my survey, thank you and please disregard this e-mail. If you have not responded to my survey, please consider doing so as your input is important to the research outcome. Your participation should take approximately 20 minutes of your valuable time.

I obtained your e-mail address from the APA Membership Registry for the years of 2000 or 2003. I am conducting an empirical research study on psychologists' beliefs and knowledge about diagnosing adolescents. Your participation in this research study is appreciated in order to have the data compiled from professionals who are knowledgeable and interested in diagnosing adolescents. Empirical research such as this is needed in the field of psychology to facilitate the developments of psychology as a profession and to assist in educating the public that the practice of psychology involves more than "just talking to someone." Practitioners of psychology consistently test and retest hypotheses in an effort to substantiate the utility of their knowledge base.

The deadline for responding to the survey is June 1, 2003. Should you choose to participate in this study, the results will be available to you on the Web site after June 30, 2003.

QUESTIONS? SEND ME AN E-MAIL

PROCEED TO INFORMED CONSENT

Appendix B
Website Introduction

Welcome to the website designed to study psychologists' beliefs and knowledge about diagnosing adolescents. As you proceed through this site, there will be an informed consent form designed and authorized by the Philadelphia College of Osteopathic Medicine describing specific informed consent details such as voluntary participation and maintaining your confidentiality. The informed consent is followed by the survey instrument which includes questions to collect demographic data. Participation should take approximately 20 minutes of your time. Because research based data is vital to the clinical practice of psychology, your responses as an expert in the area of diagnosing adolescents are of particular value.

In return for your participation in this study, I would like to share the results of this research with you. Once you have accepted the Informed Consent and completed the survey, you will be instructed as to how to access the summary results of this research. A summary is expected to be available by June 30, 2003.

To continue, please click below to proceed to the informed consent area of this website.

[PROCEED TO INFORMED CONSENT](#)

[QUESTIONS? SEND ME AN E-MAIL](#)

Appendix C
Informed Consent Form



PHILADELPHIA · COLLEGE · OF · OSTEOPATHIC · MEDICINE

DEPARTMENT OF PSYCHOLOGY
215-871-6442
215-871-6458 FAX
psyd@pcom.edu E-MAIL

TITLE OF STUDY

Psychologists' Beliefs and Knowledge about Diagnosing Adolescents

PURPOSE

The purpose of this research is to investigate the nature of psychologists' beliefs and knowledge about diagnosis in adolescents.

You are being asked to be in this research study because you are listed as a member of the Society of Clinical and Adolescent Psychology in the American Psychological Association membership register. Hence, it is presumed that you are knowledgeable about diagnosing adolescents and have an interest in empirical research studies. If you are not a member of this organization, you cannot be in this study.

INVESTIGATORS

Principal Investigator:

Name: Robert A. DiTomasso, Ph.D., ABPP
Department of Psychology at PCOM
Address: 4190 City Ave.
Philadelphia, PA 19138

Phone: 215-871-6511

Responsible Investigator:

Name: Nancy E. Madden, RN, MS, CS

Department: Doctoral Candidate in Psychology

Address: 454 Germantown Pike

Lafayette Hill, PA 19444

Phone: 610-828-0608 or e-mail Nemadden@aol.com

The doctors and scientists at Philadelphia College of Osteopathic Medicine (PCOM) do research on diseases and new treatments. The survey you are being asked to volunteer for is part of a research project for doctoral dissertation requirements.

If you have any questions about this research, you can call Dr. DiTomasso at (215) 871-6511.

If you have any questions or problems during the study, you can ask Dr. DiTomasso, who will be available during the entire study. If you want to know more about Dr. DiTomasso's background, or the rights of research subjects, you can call Dr. John Simelaro, Chairperson, and PCOM Institutional Review Board at (215) 871-6337.

DESCRIPTION OF THE PROCEDURES

This survey will take approximately 20 minutes to complete. This study involves providing a primary diagnosis for two vignettes, completing a belief and knowledge survey about diagnosis, and providing demographic information.

POTENTIAL BENEFITS

While there is no direct benefit to individual participants, the results will potentially lead to a better understanding of the diagnosis of mental illness in adolescents and contribute empirical data about diagnosing adolescents to the field of psychology. Thus, current and future psychologists may benefit from what the researchers learn from this study.

RISKS AND DISCOMFORTS

It is not reasonable to identify all potential risks in any research, but all reasonable safeguards have been taken to minimize the potential risk of damage to your professional reputation should your diagnoses be incorrect. The results of this data will be coded in such a way that your identity will not be physically attached to the final data as any IP headers and/or e-mail addresses will be deleted prior to removing the data from the computer files for statistical analysis.

ALTERNATIVES

You may choose not to participate in this survey study.

PAYMENT

You will not receive any payment for being in this study.

CONFIDENTIALITY

All information relating to your participation will be kept in a computer file accessible only via password and identification number to the researchers. Only the members of the Institutional Review Board will be able to look at these records. Your name or any identifying information will not be associated in any way with any published results or reports to scientific groups.

NEW FINDINGS

If any new information develops that may affect your willingness to stay in this study, you will be told about it.

INJURY

You should contact John Simelaro, D.O., Chairperson, PCOM Institutional Review Board at (215) 871-6337 if you think that you have not been told enough about the risks, benefits, or that you are being pressured to stay in this study against your wishes.

VOLUNTARY PARTICIPATION

You may refuse to be in this study. You voluntarily consent to be in this study with the understanding of the known possible effects or hazards that might occur while you are in this study. Not all the possible effects of the study are known.

You may leave this study at any time by selecting on of the following: clicking the on-screen button that says "I Do Not Agree," exiting the study site, surfing elsewhere, not clicking the on-screen button that says "Submit Survey."

You also understand that if you drop out of this study, there will be no penalty or loss of benefits to which you are entitled.

I have had adequate time to read this form and I understand its contents. I can print a copy of this form for my personal records.

I agree to be in this research study and understand that my informed consent is obtained when I click the on-screen button that says "I Agree" since my signature cannot be obtained via Internet.

Signature of Investigator:

Responsible Investigator:

Date: 09/12/02 Time: 10:00 AM

Q. Do you agree?

I Agree

I Do Not Agree

Appendix D

Case Vignettes of DID and Schizophrenia

Please read the vignettes and based on the information provided, assign a primary diagnosis for each. Once completed, please click on the 'Next' button at the bottom of the page. Please do not attempt to use the 'Back' button to return to this page as this research study is designed to collect the diagnosis of each vignette prior to answering the multiple choice and demographic questions.

Vignette1.

Susan is a 17 year-old female who is enrolled full time in the 11th grade at Public High School. This is the first time that she has sought services from a mental health professional. She complains of "lost periods of time." Recently, there have been hours, and even days, that she does not recall. Susan remembers some occurrences of being sexually abused as a child, but many of her childhood memories are gone. She reports that her peers have talked to her about sudden mood changes and have expressed concern about her. She admits to "not feeling like herself" sometimes but cannot explain just how. Susan thinks that she is close to failing school because of these episodes. Most distressing of all to her are voices that she hears talking to her from inside her head. She does admit to an increase of stress at school, accompanied by bouts of lethargy.

Primary Diagnosis:

Vignette2.

Susan is a 17 year-old female who is enrolled full time in the 11th grade at Public High School. This is the first time that she has sought services from a mental health professional. For more than half a year, she has been having intense "daydreams" that take up hours of her day, are perceived as real, and often feel controlling to Susan. These losses of time have had a negative effect on her academic work. Her peers have talked to her about her shifting mood sequences and increasing introversion. They have expressed concern about her. Susan thinks that she is in danger of failing school because of her deteriorating academic performance and social functioning. Most distressing of all,

however, are voices that she hears talking to her, often originating from inanimate objects such as appliances. She does admit to an increase of stress at school, accompanied by bouts of lethargy.

Primary Diagnosis:

Appendix E

Skepticism and Knowledge Scales

This research is designed to not allow a return to the Vignette Section; however, in the following section you will be able to move back and forth as you respond to the following statements.

Please indicate if you 'Strongly Disagree', 'Disagree', are 'Unsure', 'Agree', or 'Strongly Agree' with each of the following statements. (choose one for each statement)

1.
The existence of Dissociative Identity Disorder (DID), formerly Multiple Personality Disorder (MPD), as a clinical phenomenon has been demonstrated beyond any reasonable doubt.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

2.
Major trauma is a contributing factor to the development of Depersonalization Disorder.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

3.
Dissociative Identity Disorder (DID), is under-diagnosed.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

4.
Dissociative Fugue, formerly called Psychogenic Fugue, is most often a fabrication used to avoid personal responsibility.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

5.
Schizophrenia does not exist.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

6.

Dissociative Identity Disorder (DID), can be created in counseling/psychotherapy.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

7.

Dissociative Identity Disorder (DID), is a misdiagnosis of schizophrenia.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

8.

Schizoid Personality Disorder and Schizophrenia are related Axis I disorders.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

9.

Major trauma is a contributing factor to the development of Dissociative Identity Disorder (DID).

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

10.

More funding should be devoted to research on Dissociative Identity Disorder.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

11.

I would not diagnose someone as having Dissociative Fugue.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

12.
Depersonalization Disorder is over-diagnosed.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

13.
The symptoms of Schizophrenia must be present for at least six months in order for this to be a viable diagnosis.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

14.
The number of documented cases of Dissociative Identity Disorder (DID) has increased over the past two decades.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

15.

The existence of Dissociative Fugue as a clinical phenomenon has been demonstrated beyond any reasonable doubt.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

16.

Dissociative Identity Disorder (DID) is an Axis II disorder in the DSM IV-TR.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

17.

Schizophrenia is a misdiagnosis of Dissociative Identity Disorder (DID).

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

18.

Dissociative Identity Disorder (DID) is largely an excuse used by people to avoid responsibility for personal actions.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

19.

I would not diagnose someone as having Dissociative Identity Disorder (DID).

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

20.

PTSD is classified as a dissociative disorder in the DSM-IV TR.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

21.

Dissociative Identity Disorder (DID) has been diagnosed more frequently in females than in males.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

22.

Dissociative Fugue and Dissociative Amnesia, formerly called Psychogenic Amnesia, should be considered two forms of the same disorder instead of two separate disorders.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

23.

Schizophrenia is over-diagnosed.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

24.

Dissociative Identity Disorder (DID) is extremely rare.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

25.

People can fake Dissociative Identity Disorder (DID) successfully.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

26.

Schizophrenia is often a result of an organic mental disease.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

27.

The onset of Dissociative Identity Disorder (DID) is almost invariably in childhood.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

28.

All of the symptoms related to Dissociative Identity Disorder (DID) can be explained by and accurately diagnosed as another psychological factor.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

29.

People can fake schizophrenia successfully.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

30.

Dissociative Identity Disorder (DID) does not exist.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

Finally, please tell us about yourself.

D1.

What is your gender? (choose one)

- Female Male

D2.

What is your age? (choose one)

- Under 20
- 20 - 29
- 30 - 39
- 40 - 49
- 50 - 59
- 60 - 69
- 70 and over

D3.

What is the highest level of education you have completed? (choose one)

- PhD
- PsyD
- EdD
- MS
- MA

D4.

How many years have you been practicing in the field of psychology? (choose one)

- 1 - 9 years
- 10 - 19 years
- 20 - 29 years
- 30 - 39 years
- 40 - 49 years
- 50 or more years

D5.

What is your race/ethnicity? (Optional; choose one)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic
- Native Hawaiian or Other Pacific Islander
- White
- Another race or multiracial

D6.

How many seminars/conferences have you attended over the past five years in which you have learned about DID/MPD?

Number of seminars/conferences:

D7.

What is your primary work setting? (choose one)

- Private Practice
- Hospital
- University/college counseling center
- Elementary, middle or high school setting
- University/college academic position
- Community Mental Health Center
- Other

D7b.

If you selected 'Other', please explain:

D8.

Which best describes your job title? (choose one)

- Clinical Psychologist
- School Psychologist
- Counseling Psychologist
- Other

D8b.

If you selected 'Other', please explain:

D9.

Please indicate the extent to which your theoretical orientation is composed of each of the following (please assign percentages that add up to 100%)

Psychodynamic (e.g. Freudian, Sullivanian, ego psychology, self psychology, etc.)	<input type="text"/>
Learning (e.g. Behavioral, Cognitive, Cognitive/Behavioral, Social Learning, etc.)	<input type="text"/>
Humanistic (e.g. Rogerian, Existential, Gestalt, etc.)	<input type="text"/>
Other	<input type="text"/>

D9b.

If you assigned a percentage greater than '0%' to the 'Other' category, please explain.

D10.

What is the average number of children between the ages of 1 and 12 that you assess in a year?

D11.

What is the average number of adolescents between the ages of 13 and 18 that you assess in a year?

D12.

Check off any of the following organizations of which you are a member: (please check all that apply)

- American Psychological Society
- International Society for the Study of Dissociation
- International Society for Traumatic Stress Studies
- Other (please specify)

D12b.

Please specify other organization(s) of which you are a member.

Thank you for your participation in this survey.

A summary of the results will be available by June 30, 2003 by visiting

www.psychbeliefsaboutdxadol.com.

Please press the 'Submit Survey' button
at the bottom of the survey to send your responses
and for accessing study results.

