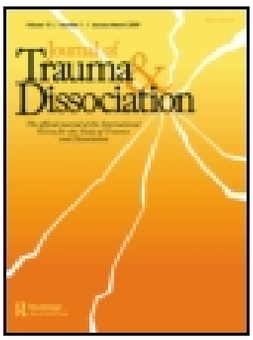

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Factitious and Malingered Dissociative Identity Disorder: Clinical Features Observed in 18 Cases

Ann Thomas, MD, FRCPC

ABSTRACT. This paper compares the clinical features of 18 persons given a diagnosis of factitious or malingered Dissociative Identity Disorder with those of 18 matched persons who were given a diagnosis of genuine Dissociative Identity Disorder, taken from a sample of 129 second opinion consultations. Clinical features suggesting a factitious diagnosis or malingering included having a score above 60 on the Dissociative Experiences Scale (DES), reporting dissociative symptoms inconsistent with the reporting on the DES, being able to tell a chronological life story and to sequence temporal events, using the first person over a range of affect, being able to express strong negative affect, bringing "proof" of a dissociative diagnosis to the consultation, having told persons other than close confidants about the alleged abuse or alleged dissociative diagnosis, reporting alleged abuse that was inconsistent with the medical or psychiatric history or volunteering allegations of cult or ritualized abuse, telling of alleged abuse without accompanying shame, guilt, or suffering, having been involved in community self-help groups, not having symptoms of co-morbid posttraumatic stress disorder, and having obvious secondary gain in having a dissociative diagnosis. Given the potential legal ramifications of making a false positive diagnosis of Dissociative Identity Disorder and recognizing that the treatment for persons with valid dissociative psychopathology differs from the treatment of factitious illness, it is prudent to be able to separate the two groups. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com>*

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INTRODUCTION

Factitious and malingered psychiatric illness can be hard to detect (Resnick, 1984; Rogers, 1988; Jones, 1995). This is particularly true of factitious and malingered Dissociative Identity Disorder (Coons, 1993; Coons & Milstein, 1994; Ross, 1997; Chu, 1998; Ross & Caldwell, 2000). For someone never taught about diagnosing Dissociative Identity Disorder, not familiar with the diagnostic interview schedules available (Ross, Heber, Norton, Anderson, Anderson, & Barchet, 1989; Steinberg, 1993), or with little experience treating persons with severe dissociative psychopathology, making the distinction between factitious or malingered genuine Dissociative Identity Disorder (DID), formerly called Multiple Personality Disorder (MPD), can be particularly difficult. Clinicians need to be able to tell the difference for risk prevention purposes (Ross, 1997; Armstrong, 1999, Brown & Scheflin, 1999; Marmer, 1999; Scheflin & Brown, 1999), for legal purposes (Coons, 1991; Lewis, 1991; Brown, Scheflin & Hammond, 1998; High, 1999), but most importantly because the treatment for those persons with genuine Dissociative Identity Disorder differs from the treatment for those persons with factitious illness (Ross, 1997; Chu, 1998; Ross & Caldwell, 2000).

In 1978, Coons reported on the phenomenon of "pseudomultiplicity" in a person who had adopted dissociative symptoms on a hospital ward from the close proximity to another patient with genuine MPD. In 1987, Kluft described six cases of factitious MPD suggesting that the clinical characteristics in factitious cases were not that difficult to differentiate from valid cases of MPD. In 1990, Coons and Grier reported a case of a patient with factitious illness making allegations of Satanic ritual abuse. In 1991, Chu published a case report, cautioning clinicians against making a false positive diagnosis of multiple personality disorder. Coons and Milstein (1994) suggested that patients were becoming more sophisticated and that factitious presentation was getting harder to differentiate. They presented 11 case reports, in which they paid particular attention to the characteristics of factitious illness or malingering. They listed "a chronic severe disability since adolescence, lack of consistent work history, dramatic and exaggerated presentation of symptoms, pseudologica fantastica, demanding and depreciating attitudes toward health care workers, refusal of collateral examinations, selective amnesia, hospital seeking behavior, and a psychological need to assume the sick role" (p. 85) as differentiating factors.

Draijer and Boon (1999) compared cases of "simulated" Dissociative Identity Disorder to genuine cases of Dissociative Identity Disorder commenting

on the core dynamics of the "simulators" which were the avoidance of responsibility for negative behavior and compensation for an overwhelming feeling of not being seen. They observed that DID patients have a "reluctance, ambivalence or shame about revealing the presence of symptoms such as amnesia or identity fragmentation" (p. 429). They commented that the DID patients seemed to be genuinely suffering from their condition. They also observed differences in the reporting of questions on the (SCID-D), particularly genuine feelings of depersonalization, derealization and identity confusion. The imitated group were not seen dissociating during the SCID-D interview and had no difficulty in talking about their alter personalities. They suggest that "clinicians who are not experienced or trained in the field of dissociative disorders are at risk for making a false positive diagnosis or confirming the ideas of the imitated DID" (p. 453) which may put them at risk for law suits or inappropriate treatment.

This paper presents a further sample of persons diagnosed with factitious or malingered DID and suggests 12 clinical differences between persons with factitious or malingered DID and persons with genuine DID.

METHOD

Author

The author has had an interest in trauma and dissociation for over two decades, and has specialized in the diagnosis and treatment of these disorders for over a decade. The author has systematically used the Dissociative Experiences Scale (DES) and Structured Clinical Interview for the Dissociative Disorders (SCID-D) questions in conducting diagnostic evaluations.

Instrument

The Dissociative Experiences Scale (DES) is a 28-item self-report questionnaire (Bernstein & Putnam, 1986) that has been shown to have good reliability and validity and can be used as a screening instrument for dissociative disorders.

Diagnosis

Over the period of time of this study, there have been two diagnostic criteria for Dissociative Identity Disorder, formerly called Multiple Personality Disorder. For a diagnosis of Multiple Personality Disorder, the DSM-III-R (American Psychiatric Association, 1987) required the existence within the individual of two or more distinct personalities or personality states, each with its own

relatively enduring pattern of perceiving, relating to and thinking about the environment and one's self, plus the requirement that each of these personality states at some time, and recurrently, takes full control of the person's behavior. Because of a belief that amnesia was a necessary part of the diagnosis, and wanting to emphasize that there was one personality with dissociated aspects of the self (Cardeña, Lewis-Fernandez, Beahr, Pakianathan, & Spiegel, 1996), the DSM-IV (American Psychiatric Association, 1994) added a requirement of inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness, plus that the disturbance must not be due to the direct effects of a substance or general medical condition and changed the name to Dissociative Identity Disorder.

Witnessing identity alteration within the interview situation, as well as having evidence of dissociative amnesia, has always been required by the author to make a definitive diagnosis of either MPD or DID; therefore, all persons given a diagnosis of MPD or DID fit under the current requirements of the DSM-IV for a diagnosis of Dissociative Identity Disorder.

According to the DSM-IV, Factitious Disorder requires the intentional production of signs and symptoms motivated by wanting to assume the sick role without any external incentives for this behavior such as economic gain, or avoiding legal or other responsibility. Malingering is the intentional production of signs and symptoms with evident external incentives for the behavior.

For the purposes of this paper, the origins of the factitious or malingered presentation were not explored other than what was obvious. Also, for the purposes of the clinical comparisons of this paper, factitious illness and malingering have been combined, and will be referred to as the factitious group.

Subjects

From July 1, 1990 to December 31, 2000, 129 adult outpatients suspected of having DID were referred to the author for consultation regarding diagnosis or recommendations for treatment. Prior to the psychiatric assessment interview, all but two patients completed the DES. During the subsequent interview(s), systematic inquiry of dissociative symptoms was part of the mental status exam. Hypnosis was never used during the assessment.

Prior to 1993, the Dissociative Disorders Interview Schedule (Ross, Heber, Anderson, Anderson, & Barchet, 1989) was used to make a diagnosis of MPD; thereafter, a systematic enquiry of dissociative symptoms according to the guidelines of Steinberg (1993), as well as the overall history and presentation of the patient (Loewenstein, 1991), was used.

In this sample of 129 subjects, 73 persons fulfilled DSM-IV criteria for DID, and 26 fulfilled criteria for either posttraumatic stress disorder (PTSD) or dissociative disorder not otherwise specified (DDNOS). Some of these 26 per-

sons may have had DID, but identity alteration and amnesia were not witnessed within the interview situation so a conservative diagnosis of PTSD or DDNOS was given. Eighteen persons, 15 women and three men, were diagnosed with either factitious DID or malingered DID. Twelve persons in this sample had no evidence of dissociative symptoms whatsoever; four of these individuals met the criteria for a primary diagnosis of schizophrenia and eight had another Axis I primary diagnosis.

Given the experience of assessing numerous people for a suspected diagnosis of DID, and having conducted psychotherapy with many people with genuine DID, the author hypothesized a series of clinical features that appeared to be different in the two groups, then did a chart review to see if these clinical impressions were born out. For the purposes of the comparisons in this paper, the 18 persons who were given a diagnosis of factitious or malingered Dissociative Identity Disorder were matched as closely as possible by sex, age, marital status and number of children with 18 persons who were given a diagnosis of MPD or DID. Statistical analysis revealed no significant differences on these parameters.

OBSERVATIONS

From several potential differences between the two groups, 12 symptom clusters appeared to be relevant.

1. Differences on the DES Scores

Two persons in the factitious group did not complete the Dissociative Experiences Scale. Fifteen of the remaining 16 patients had a DES score over 25. The 16th person answered 0 to every question, yet at interview verbally claimed she had dissociative symptoms. This person appeared to parrot statements presumably made to her by her therapist, such as "My therapist has taught me about past life regressions," "I have dissociation; I get into different alters," and "I need to get into tune with myself." She had apparently no dissociative symptoms prior to entering psychotherapy for depression.

Nine of the 16 persons in the factitious group who answered the questionnaire had a DES score of 60 or above, compared to only four persons in the matched genuine group. This difference is not statistically significant. There was no statistically significant difference between the factitious and the genuine groups in the overall DES scores.

All persons except one in genuine group had a DES score above 25. The one low score of 10 was from a woman whose referral was initiated by a child welfare agency about her fitness to parent. Dissociative symptoms were very evident during the interview despite her attempts to minimize her symptoms. In

the genuine group, those who had DES scores above 60 had clinical features at interview consistent with the high DES scores. For example, one woman who said she was having memory problems 100% of the time, was observed to spontaneously switch through numerous alter states, frequently being confused about or unaware of what had just been said.

2. Reporting of Dissociative Symptoms

In conducting the inquiry into each of the dissociative symptoms (Steinberg, 1993), all persons in the factitious group had differences between what was indicated on the DES and what was presented in the interview situation. Several persons had subscale amnesia scores (Smyzer & Baron, 1986) over 50 but could give no specific examples. Examples of amnesia given by others differed in substance from what is seen with genuine DID patients. The only example given by one woman was not remembering what her child looked like at birth. Another person's only example was finding herself on a subway platform and not knowing where she was, on the specific date of November 10, 1985.

The reports of amnesia by the DID patients fit with the answers indicated on the DES. The reports never included a specific date, and had the character of a memory gap, such as, "I am married with two children but I have no memory of ever having had intercourse with my husband," or "I leave for a 10 minute drive to work, get there three hours later, and have no idea where I was for the three hours."

In describing depersonalization, the members of the factitious group sometimes described being *in* the body and having the allegedly depersonalized part being *outside* the body, for example, "I could see myself floating above the floor" or " I am a little imp sitting on a moonbeam." Specific dates were sometimes given, as in "from age three months to age two years I could float through the air."

The DID patients would spontaneously use the language of "going in," "going back" or "going into the light" with an inability to explain what they meant or how to explain this personal experience. The description of the dissociated part would be outside the body describing what the body was doing, as in "I watch myself having sex" or "I can see myself swearing at my children, in words I would never use." Sometimes the description would include the observation of a dissociated part of the self, such as "I sit and watch Ruth do all the housework" thereby including the symptom of identity alteration in a question exploring depersonalization.

Despite indicating otherwise, specific examples of an episode of derealization were very hard, frequently impossible, for the persons in the factitious group to give. The DID patients had no difficulty in producing an example

such as "I drive around and around the block and cannot figure out which house is mine," "They tell me I am in the hospital but I would swear I am in Fort Erie," or "The nurses say it is winter and there is snow on the ground, but I am sweating and it looks like Alabama to me."

The factitious patients answered questions about identity confusion in a preposterous way as in "I weigh 985,000 pounds" or "I am the headless horseman." Despite talking about alleged identity confusion, the pronoun "I" was always used and if third person self-reference was attempted, it was not consistent over the time of the interview.

DID clients readily produced an example of identity confusion, such as "My therapist says I call myself different names," and "I often change my clothes many times before *they* let me go out of the house."

Factitious patients frequently answered questions about identity alteration positively, yet demonstrated neither shifts in demeanor, voice tone, facial expression, or behavior nor deviation from the pronoun "I" with their examples. If a voice in the head was acknowledged, it was not associated with a behavior or an affect state. Representative statements are "I had my first voice at age two years, 4 months and 7 days" or "When I was eight, I developed a tree." Explanations of the stated dissociative symptoms given by the factitious clients included "the Prozac gave me MPD," or "It's just switch, switch, switch" said in a sing song voice, or "It's like being in a revolving door at a store; someone just pops out," or "It is like the ducks at a shooting gallery; you never know who, when or why someone will pop up."

The DID clients would frequently spontaneously exhibit identity alteration in the session as in "I am not Susan (legal name), I am Sarah" or "Isn't Daphne (legal name) pathetic?" They were able to link the shifts to a behavior or to an affect state, for example, "When I am angry, Pam takes over and when I am sad, Pamela is here," "They said I was dancing but I do not know how to dance," "Marie has sex, Stockbroker goes to work, and Big John gets angry."

In the clients with Dissociative Identity Disorder, inquiry about one dissociative symptom would frequently get an answer that included another dissociative symptom. This production of two dissociative symptoms in answering one question or on giving one example never occurred with the factitious patients.

3. Ability to Tell a Chronological Life Narrative, to Sequence Time and to Mentally Juggle Time Concepts

In the factitious group, all persons were able to give specific dates and temporal data regarding their life history. There was no difficulty in sequencing events, in juggling time in their head, or in presenting a chronological life his-

tory. In all cases, inconsistencies and items of mutually exclusive pieces of biographical information were observed over the course of the interview.

All members of the DID group demonstrated inability to sequence time and to present a chronological life story. There were many specific dates, such as birthdays, wedding dates, and birth dates of children that could not be remembered. There was no ability to use one piece of temporal data to work out another, for example "That happened when I was in grade three so I must have been aged nine." Rather than inconsistencies in the story telling, episodes of amnesia were noted and if these memory gaps were drawn to the person's attention, puzzlement or confusion was expressed.

4. Personal Self-Reference and Expression of Affect

All members of the factitious group used the pronoun "I" throughout the interview, even when discussing alleged dissociative experiences, after having allegedly switched, or when allegedly being in an altered state. Over the course of the interview, a range of affect was expressed. Transitions between the expressions of different affects were smooth and the expressed affect was congruent with the topic of conversation.

In the DID group, on at least one occasion, all persons used the third person pronoun or a different name in referring to themselves. The third person self reference remained consistent over the course of the interview and consistent with the affect or material being presented. Over the initial period of the interview, overall affect tended to be constricted, flat, or controlled. The expression of strong affect, such as anger or intense shame, was accompanied by a sudden dramatic mood shift, a switch to an alter, and frequently by a memory gap. The context for the affect was congruent with the material being presented and the switches were consistent over the time of the interview.

5. Expression of Strong Negative Affect

All members of the factitious group were able to express strong affects such as anger or disgust. They could tell of a personal experience where one would have expected a strong affect such as anger, fear or shame to be present, without any discomfort or switch to an alter personality. Examples of statements with observable affect given by persons in the factitious group include "My husband is a lazy bum; I thumped him good," and " I'm pissed off at welfare and at my husband who pays no support." Examples of statements where one would have expected some discomfort, some affect or a switch if the person really did have DID, include "I bought myself a vibrator, mounted it on the bed and self-abused with it," and "When I got pregnant from my father, I told my mother that if she didn't pay for the abortion, I would."

The members of the genuine group would usually present with flat affect. Strong affect was usually denied, avoided, or reported in a dissociated state as in "I don't get angry but sometimes I am outside myself and I can't believe what I am saying," or "There's my loving kind self, my angry hateful self, my joker self and a kid" or, "I cannot say 'No'; my Avon lady comes out if *we* have to be assertive." If strong negative affect was expressed, a dissociative switch usually accompanied it. One man, after discussing his problems getting social assistance, suddenly angrily said, "I hate all that bureaucratic trash; by the way I am Joseph, he's (host) such a wimp."

6. Objects Brought to the Consultation

Eight of the eighteen persons given a factitious diagnosis brought articles such as posters, journals, or collages aimed at proving their MPD/DID diagnosis with them to the consultation interview. These items were spontaneously offered to the interviewer to "prove" their diagnosis. One woman brought two garbage bags filled with art works that she presumed would verify that she was a multiple. One woman brought a large three ringed binder, neatly tabbed with each of the alters listed and diligently described. One person brought copies of the handwritten notes of her therapist with over one hundred alters meticulously described. Three persons brought affidavits from a therapist avowing that the person suffered from MPD.

Only four of the persons in the DID group brought anything to the interview. Two persons brought a one-page note from their therapist. One person brought a journal that was only proffered from her purse when questioned about handwriting changes. Another person offered to show her sketch book with pictures of sadistic acts she had no memory of drawing when asked about memory gaps.

7. Self-Disclosure of Alleged Abuse, Symptoms or Diagnosis to Other People

All members of the factitious group had told many others, often a group of people, about their alleged symptoms, alleged abuse, or alleged diagnosis.

Members of the genuine group were very private about their difficulties and had made self-disclosures about the abuse, their symptoms or their diagnosis to at most three other people, usually their doctor and/or therapist plus at most one trusted friend or a partner. No one in the genuine sample had disclosed their symptoms, abuse, or diagnosis to any group.

8. Disclosures About Alleged Abuse During the Consultation

Thirteen members of the factitious group spontaneously volunteered information about specific examples of alleged horrific childhood physical or sex-

ual trauma, often in intricate detail. The disclosure was not accompanied by a switch to an altered state or by the affect one might expect from such a terrible personal experience. On direct inquiry, two members denied any childhood abuse. The abuse allegations were frequently not consistent with the medical history; for example, one woman alleged numerous episodes of sodomization as a child, but denied any symptoms or problems referable to her bowels. Five persons volunteered Satanic or ritualized abuse. I never inquire about ritualized abuse.

In the DID group, episodes of childhood abuse were never volunteered except as a general statement about being molested or physically or sexually abused. With any direct inquiry about childhood trauma, there was a reluctance and anxiety at disclosure. Statements about alleged abuse were of a general nature and if any specifics of an abusive episode were given, such a disclosure would be accompanied by visible upset or a shift to an altered state. No one volunteered any history of Satanic or ritualized abuse.

9. Presence of Shame, Guilt, and Suffering

None of the factitious group exhibited any shame in talking of their alleged abuse, symptoms, or past history. There was no guilt or blaming of the self for the alleged problems. Only one person appeared to be suffering as she talked about the emptiness in her life. This woman stated a belief that a diagnosis of DID, which was treatable, would be preferable to the diagnosis of borderline personality disorder that she had been given, which she had been told was untreatable.

All persons in the DID group exhibited significant shame affect within the interview. All expressed diminished self-esteem and intimated a sense of responsibility about the abuse or trauma. All except one person gave the impression of significant suffering. The woman who was an exception was referred because of a social services assessment that she was unable to parent her children, and she tried desperately to present herself in a competent fashion.

10. Involvement in Community Self-Help Groups

Thirteen persons in the factitious group had been involved in at least one community self-help group. Frequently this would be an adult children of alcoholic's group, an incest survivor's group, or a support group for persons with MPD/DID. One person had attended a SAFE (Self-Abuse Finally Ends) group. Only five persons had no group involvement.

In the DID group, at the time of the interview, only one person was attending a SAFE group run by two leaders knowledgeable in dissociative pathology. One person had attempted to attend an incest survivor's group, but quickly dropped out because of being overwhelmed with flashbacks. Another

person began episodes of severe self-abuse after attending the first session of an incest survivor's group and attended no further sessions. One person, trained in the social services field, had worked as a group leader; she had never attended a group where she was a member. The remaining 15 persons had no group involvement whatsoever.

11. Presence of Posttraumatic Symptoms

None of the members of the factitious group had symptoms consistent with a diagnosis of posttraumatic stress disorder. Although several members spoke of nightmares or flashbacks, there was no accompanying persistent avoidance of stimuli associated with the trauma, or persistent symptoms of increased arousal, which are necessary for a DSM-IV diagnosis of posttraumatic stress disorder.

Eleven of the 18 members of the genuine group had symptoms of persistently re-experiencing the trauma through nightmares, dreams, or flashbacks, behavior signifying avoidance of reminders of the trauma, and symptoms of increased arousal such as hypervigilance, an exaggerated startle response, and panic attacks, which were sufficient for a co-morbid diagnosis of posttraumatic stress disorder.

12. Motivation for Consultation

Eight persons in the factitious group were seen as a prerequisite for entry into an out-of-country specialized inpatient dissociative disorder treatment program. Three people appeared to use the Dissociative Identity Disorder diagnosis to avoid responsibility. Two people had their identity and social network wrapped up entirely in being part of a Multiple Personality Disorder group or an incest survivor's support group in their respective communities. Both were referred because their therapists felt stuck in the therapy.

One person denied early childhood trauma, and denied dissociative pathology prior to seeing a psychiatrist for treatment of depression. She was the only patient this psychiatrist had treated for DID and arrived with *his* documentation of her alters (different from the example in #6). She was one of the few factitious patients who were happy that the dissociative diagnosis was negated because it meant she could regain custody of her son.

One person had developed her symptoms while in hospital for depression, housed in a room with a person with DID. Three persons needed confirmation of the diagnosis of DID to maintain long-term disability benefits.

In the DID group, two persons wanted no treatment whatsoever and had only attended the consultation at the insistence of an agency or a family member. Three persons needed confirmation of the diagnosis to have funding for treatment continued. One person was seen at the request of an agency regard-

ing fitness to parent. The remaining 12 persons were referred by a psychiatrist or a therapist for confirmation of the diagnosis or directions for the therapy. Each of these persons wanted to get better and to stop the suffering. They verbalized that they would do anything that would help them achieve that goal.

DISCUSSION

In knowledgeable hands, the SCID-D is able to differentiate imitated DID from genuine DID (Steinberg, 1993; Boon, Hoeve/Roosenburg, & Dolder 1999; Draijer & Boon, 1999; Fraser, Welburn, Cameron, Webb, Kanisberg, & Raine, 1999). However, not every community clinician who encounters a patient with dissociative symptoms will have the time, interest, or the expertise to use the structured clinical interviews (Ross, Heber, Norton, & Anderson, 1978; Steinberg, 1993) for a definitive diagnosis of DID, although this would definitely be preferable for risk prevention purposes (Frankel & Dalenburg, 2000). Thus, having a series of clinical observations, which might help the clinician suspect a factitious or malingered presentation, might be a welcome addition to the diagnostic armamentaria.

There have been many attempts to use instruments to help differentiate the factitious from the real (Antens, Frischholz, Brown, & Sachs, 1991; Gilbertson, Torem, Cohen, Newman, Radojicic, & Patel, 1992). This study does not replicate the findings of Antens et al. (1991) who found a statistically significant difference on DES scores between factitious MPD and genuine MPD cases. However, elevated DES scores should raise the suspicion of a factitious presentation and guide the clinician to be more rigorous in the exploration of dissociative symptoms. Over-endorsing questions DES is consistent with a motivation of wanting the diagnosis.

At interview it is important to rigorously and systematically inquire about dissociative symptoms, particularly as they correspond to the answers given on the DES. Although persons with DID might be reluctant or reticent to acknowledge dissociative symptoms (Draijer & Boon, 1999; Putnam, 1999), nevertheless, they are able to speak of their experience with authenticity despite some difficulty putting these experiences into words (Steinberg, 1993). The reporting of these symptoms by the genuine patients is consistent with the reporting on the DES. This was not true of persons with simulated illness.

The dissociative amnesia, which is part of the definition of DID (DSM-IV), makes it impossible for the patients with DID to reliably track time. Time concepts are an ongoing issue for persons with DID (Putnam, 1989; Ross, 1997; Chu, 1998). The dissociation of parts of the person's identity and experience make it virtually impossible for the DID patient to integrate pieces of information from disparate parts of their life narrative into an integrated report. This

finding can be very apparent at interview especially if the person is asked to associate questions of age, place of residence, grade at school, and other family information. The factitious patients, who do not have dissociative amnesia, can do these mental calculations readily.

The definition of DID requires the existence of at least two identities or personality states which recurrently take control of a person's behavior, therefore there are at least two "I's" or stated differently, at least one "me" and one "not me." This experience of the person with DID becomes evident with the person's use of pronouns throughout the interview (Putnam, 1989; Loewenstein, 1991; Ross, 1997; Chu, 1998). Since having more than one "I" or "me" is not the ongoing experience of the person with a factitious presentation, it is difficult for the person to keep the pronouns straight and consistent throughout the interview.

Inability to modulate strong affect is one of the hallmarks of the person with DID. Teaching the person to self-soothe, tolerate different affect states and modify affects is an ongoing issue in the treatment of a person with DID (Putnam, 1989; Phillips & Frederick, 1995; Ross, 1997; Chu, 1998; van der Hart, Nijenhuis, & Steele, 2000). Shame is pervasive through the presentation of a person with DID (Lewis, 1992; Peterson, 2000). In persons with genuine DID, strong affects are denied and/or dissociated. To be able to express strong affect, especially with a stranger, is not an ability most persons with DID possess.

Persons with DID do not want the diagnosis. Having been neglected or abused is information that is defended against even after therapy is well established with a trusting therapist, even more so if there has been a ritualized component (Kluft, 1987; Putnam, 1989; Ross, 1997; Chu, 1998). There is too much guilt and shame attached to make such a disclosure readily. Persons with DID do not volunteer information about the specifics of any personal experience that would elicit feelings of horror, shame, humiliation, guilt or disgust. Drawings and handwriting changes indicative of an altered state, and socially unacceptable behavior which has been committed, are denied, disavowed, or presented with shame and guilt, even after years of therapy (Draijer & Boon, 1999). To offer items to "prove" a diagnosis of DID, to tell other persons, especially a group of persons, about alleged abuse, alleged symptoms, or a dissociative diagnosis, or to volunteer specific information about abusive episodes is not the usual behavior of persons with genuine DID.

DID is considered to be a post-traumatic condition (Spiegel, 1984, 1986; Putnam, 1989; Chu, 1991; Ross, 1997), therefore other symptoms of posttraumatic stress are frequently present. One of the features of posttraumatic stress is avoidance of reminders of the trauma. For this reason, patients with DID cannot tolerate a group setting where the material of other persons can trigger their own memories (Kluft, 1984). Caul (1984) suggested "The place-

ment of a multiple in a heterogeneous group proves to be disastrous for the multiple and disruptive to the group process." Clinicians who have attempted to run groups of patients with DID emphasize the necessity of keeping traumatic material away from the group to prevent regression (Braun, 1984). Having been part of a community self-help group is therefore not the experience of persons with genuine DID. It is interesting that while the factitious clients readily tried to mimic dissociative psychopathology, none attempted to simulate posttraumatic symptoms.

Coons and Milstein (1994) emphasized the features of secondary gain in the description of his series of factitious patients. Having a secondary gain in having a dissociative diagnosis, whether it is to assume the patient role as in the case of factitious illness, or to avoid some responsibility as is the case with malingering, was not explored in depth in this series; nevertheless, motivational features were evident in most of the cases.

Dissociative Identity Disorder is increasingly being recognized and is probably more prevalent than has previously been appreciated (Ross, Norton, & Wozney, 1989; Ross, 1991). The prevalence of simulated Dissociative Identity Disorder is unknown but clinicians working in the dissociative field recognize that simulation is a distinct possibility (Coons, 1978; Kluft, 1987; Coons, 1990, 1994; Chu, 1991; Ross, 1997; Draijer & Boon, 1999). Coons and Milstein (1994) have suggested it may be as high as 10% of persons seeking second opinion of a dissociative disorder specialist. In this series, 14% of the referrals were given a factitious or malingered diagnosis. This higher percentage may reflect that, for three years, the author was a gatekeeper for funded referral to a specialized dissociative disorder inpatient treatment program.

Since, increasingly, it is recognized that persons with Dissociative Identity Disorder have a potentially treatable condition (Kluft, 1984, 1994; Putnam, 1989; Barach, 1997; Ross, 1997; Chu, 1998), it behooves every clinician to make the diagnosis as soon as possible. It has been shown that many patients are in the psychiatric system for years getting inappropriate treatment before accurate diagnosis and appropriate treatment is given (Kluft, 1985, 1991; Putnam, 1986). Persons with factitious DID also have a serious illness, but the treatment for factitious DID is different from those with genuine DID (Chu, 1998). Ross and Caldwell (2000) believe that factitious DID is treatable as long as a therapeutic alliance can be forged and the therapist guards against a negative counter-transference because of the factitious presentation.

To make a false positive diagnosis of DID also puts the clinician at significant risk for future legal problems (Armstrong, 1999; Brown & Scheflin, 1999; Draijer & Boon, 1999; Marmer, 1999; High, 1999; Scheflin & Brown, 1999).

CONCLUSIONS

After making the above comparisons, I am proposing twelve clinical observations that might assist in differentiating factitious or malingered DID from genuine DID. These are:

1. Having a score greater than 60 on the DES
2. Reporting dissociative symptoms at interview that are inconsistent with the reporting on the DES and in a manner different from what is usually seen in clients with genuine DID
3. Being able to tell a chronological life story, to sequence time, and to perform mental associative time calculations
4. Using the first person self reference in the interview, even when expressing a wide range of affect, and/or while allegedly in an altered state
5. Having the ability to express strong negative affects, particularly anger, fear, disgust and shame, during the interview, or telling of doing behavior associated with strong negative affect, without distress, disavowal or an observable dissociative switch
6. Bringing objects as "proof" of a DID diagnosis to the consultation visit
7. Having told persons other than close confidants of the alleged abuse, dissociative symptoms or dissociative diagnosis
8. Volunteering specifics of alleged trauma or abuse, especially if it is inconsistent with the medical or psychiatric history; volunteering cult or ritualized abuse within the consultation visit
9. Telling of alleged abuses without accompanying shame, guilt, or an experience of suffering
10. Having been a member of a community self-help group
11. Not having co-morbid symptoms of posttraumatic stress disorder
12. Having secondary gain in having a dissociative diagnosis

In this sample, persons who were given a diagnosis of factitious or malingered DID had a minimum of 8 of the 12 listed characteristics. Persons who were given a genuine diagnosis of DID had at most 3 of these features.

Although the findings of this study are consistent with prior clinical literature and reinforce other clinical observations, the study should be regarded as exploratory rather than conclusive. Most important, the findings are based on one investigator's clinical experiences and inferences, and it is an open question as to whether an independent clinician would draw the same conclusions from the clinical data. Moreover, the hypotheses investigated were not generated independently of assignment of patients to the factitious or genuine groups; rather, the review of the clinical data merely systematized and expli-

cated the basis on which the clinical decisions were made. Furthermore, the sample was relatively small and based on a selective outpatient referral population; hence the generalizability to other settings remains to be tested.

It is hoped that with increased ability to differentiate between those with factitious Dissociative Identity Disorder and those with genuine Dissociative Identity Disorder, some of the controversy regarding the diagnostic category of Dissociative Identity Disorder (Merskey, 1995; Brown, Scheflin, & Hammond, 1998; Ross, 1997; Ross & Caldwell, 2000) can abate and energy can be directed toward learning more about dissociation and toward developing treatment skills for persons with Dissociative Identity Disorder, and for persons with factitious disorders.

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