

# Objective Documentation of Child Abuse and Dissociation in 12 Murderers With Dissociative Identity Disorder

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*Objective:* The skepticism regarding the existence of dissociative identity disorder as well as the abuse that engenders it persists for lack of objective documentation. This is doubly so for the disorder in murderers because of issues of suspected malingering. This article presents objective verification of both dissociative symptoms and severe abuse during childhood in a series of adult murderers with dissociative identity disorder. *Method:* This study consisted of a review of the clinical records of 11 men and one woman with DSM-IV-defined dissociative identity disorder who had committed murder. Data were gathered from medical, psychiatric, social service, school, military, and prison records and from records of interviews with subjects' family members and others. Handwriting samples were also examined. Data were analyzed qualitatively. *Results:* Signs and symptoms of dissociative identity disorder in childhood and adulthood were corroborated independently and from several sources in all 12 cases; objective evidence of severe abuse was obtained in 11 cases. The subjects had amnesia for most of the abuse and underreported it. Marked changes in writing style and/or signatures were documented in 10 cases. *Conclusions:* This study establishes, once and for all, the linkage between early severe abuse and dissociative identity disorder. Further, the data demonstrate that the disorder can be distinguished from malingering and from other disorders. The study shows that it is possible, with great effort, to obtain objective evidence of both the symptoms of dissociative identity disorder and the abuse that engenders it.

(Am J Psychiatry 1997; 154:1703-1710)

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The diagnosis of dissociative identity disorder (formerly called multiple personality disorder) is usually not made until adulthood (1), long after the extreme maltreatment thought to engender the condition has passed. Therefore, although there is a consensus that the most common cause of the disorder is early, ongoing, extreme physical and/or sexual abuse (2-6), accounts of such abuse are usually provided retrospectively by the patient and lack objective verification. As Putnam (1) said, "In most reports, including the NIMH survey, there is no outside verification that any trauma actively occurred."

Coons (7) recently attempted to verify abuse histories in a group of 19 children and adolescents through interviews with families and "collateral reports from numerous sources." The extent to which abuse was documented in each case was unclear. Because neither the

symptoms nor the abuse engendering them have ever been documented objectively in a group of dissociative identity disorder patients of any kind (children, adolescents, adults, or murderers), both the diagnosis and its etiology in childhood maltreatment have met with criticism ranging from skepticism to scorn (8-15).

The diagnosis in felons is doubly suspect. The prospect of facing the consequences of a serious offense invites malingering (16, 17). Dinwiddie and colleagues (18) asserted that the disorder, especially in forensic cases, could not be distinguished from malingering. Orne and colleagues (19) suggested that the most objective means of making the diagnosis in forensic cases was through interviews with family members and others who had observed the characteristic behavioral changes in the individual before he or she had committed a particular offense. To date, however, there have been no such systematic studies of groups of felons with dissociative identity disorder or, for that matter, of any other series of adult patients with the disorder. Carlisle (20) described 13 murderers suffering from multiple personality disorder but provided few objective data to support the diagnosis or its etiology. Coons (21) collected information on a group of

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TABLE 1. Child and Adult Symptoms and Signs of Dissociation and Sources of Confirmatory Data for 12 Murderers With Dissociative Identity Disorder

Subject	Sex	Age (years)	Symptoms and Signs in Childhood	Symptoms and Signs in Adulthood	Corroboration of Symptoms
1	M	40	Considered "possessed"; vivid imaginary companions; auditory hallucinations; dramatic demeanor changes	Trances; vivid imaginary companions; voice changes/switches to foreign-sounding language; different names/handwritings; command hallucinations; amnesias; two male personality states identified	Mother, sister, aunt; police records; legal assistant's notes; handwritten documents and letters
2	M	32	Trances ("phasing out") since age 15 months; called "possessed"; vivid imaginary companions; auditory hallucinations; episodic shaking with eyes open; considered epileptic	Trances; voice, accent, demeanor changes; different names/signatures; wrote different ages on forms; auditory hallucinations; amnesias; three male personality states identified	Mother, brother, wife, teacher, housemates; handwritten documents and letters
3	M	41	Trances; fugue states; called "possessed"; vivid imaginary companion; auditory hallucinations; amnesias	Trances/"conscious blackouts"; voice and demeanor changes; regression to small child; legally changed name to that of most powerful alternate personality; different signatures/handwritings; auditory hallucinations; amnesias; three male personality states identified	Wife, brother, sister, friends, neighbors, co-workers; court records of legal name change to that of alternate personality; handwritten documents and letters
4	M	33	Trances ("glassy eyed"); fugues (age 8, found across town; age 14, found in distant state); vivid imaginary companions; auditory, visual, and tactile hallucinations; amnesias; falling and shaking episodes; considered epileptic	Trances/time loss; vivid imaginary companions; voice and demeanor changes/dresses and sounds female; different clothing (sizes, sexes); different names/handwritings; auditory hallucinations; amnesias; two female and four male personality states identified	Mother, father, brother, friends, cell mates; prosecution psychiatrist interviewed alternate personalities; trial transcripts; police audiotapes; handwritten documents and letters
5	M	30	Fugues; vivid imaginary companion; auditory hallucinations; amnesias; wore girls' panties and sanitary napkins	Trances (i.e., "astral projection"); fugues/time loss; voice and demeanor changes/dresses as a female; different names/signatures/handwritings; different visual acuities; auditory hallucinations; amnesias; two female and four male personality states identified	Mother, brother, aunt, uncle, stepmother, stepfather, childhood friend; adult and child psychiatric/psychological records; school records; handwritten documents and letters
6	M	22	Trances; fugues; vivid imaginary companions; auditory and visual hallucinations; considered epileptic	Trances (i.e., "astral projection"); fugues/blackouts without alcohol; vivid imaginary companions; voice and demeanor changes; different names/signatures/handwritings; different drawing styles; different visual acuities; auditory hallucinations; amnesias; one female and three male personality states identified	Mother, siblings, cousin, schoolteacher, prison psychiatrists; handwritten documents and letters
7	M	21	Trances; vivid imaginary companion; auditory hallucinations	Trances/blackouts without alcohol; fugues; vivid imaginary companions; voice and demeanor changes; different names/signatures/handwritings; auditory hallucinations; feels controlled from outside; amnesias; two female and five male personality states identified	Mother, father, grandmother, sister; handwritten documents and letters
8	M	46	Vivid imaginary companions; hospitalized for two episodes of hysterical paralysis (ages 9 and 10); talked to self as if to someone else	Trances/blackouts without alcohol; voice and demeanor changes; regression to baby talk; different names; auditory hallucinations; amnesias; one female and two male personality states identified	Mother, ex-girlfriend, wife, relatives
9	F	36	Vivid imaginary brother; auditory hallucinations	Time loss; voice and demeanor changes/dresses and sounds male; different names; auditory hallucinations; amnesias; diagnosed/treated for alleged psychomotor epilepsy (normal EEG); one other male personality state identified	Parents, child, teenaged accomplice, housemates; neurologist's report
10	M	43	Auditory hallucinations; amnesias; dizziness, falling spells; considered epileptic	Trances/dreamlike states; fugues/time loss; vivid imaginary companions; voice and demeanor changes; different names/signatures/handwritings; refers to self in third person; command hallucinations/hears voices arguing; visual hallucinations; amnesias; four male personality states identified	Mother, aunt, friends; handwritten documents and letters

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TABLE 1 (continued)

Subject	Sex	Age (years)	Symptoms and Signs in Childhood	Symptoms and Signs in Adulthood	Corroboration of Symptoms
11	M	41	Counseling regarding sexual behaviors (age 13); listed different names at different times for parents	Time loss; voice and demeanor changes/dresses and sounds female; different names/signatures/handwritings; auditory hallucinations; amnesias; two personality states, one female and one male, identified	Aunt, co-workers, acquaintances; handwritten documents and letters
12	M	15	Trances; rapid changes of demeanor, mood, and behavior noted (age 6); vivid imaginary companion; talked to self as if to someone else; drew person with seven or eight ears, two mouths, split in half (age 6)	Trances/blackouts without alcohol; different names/signatures/handwritings; voice/accent changes; command hallucinations; observed hitting self, yelling at self; amnesias; one other male personality state identified, three more suspected	Mother, brother, mother's friend, uncle, great-aunt, grandmother, jail guard; psychiatric hospital record (age 6); other psychiatric/social services records; police reports and witness statements; handwritten documents, letters, drawings

18 murderers alleged to have suffered from multiple personality disorder; his data were gleaned in great measure from newspaper accounts and legal decisions. For lack of objective documentation of symptoms or abuse, in most instances the diagnosis was disbelieved.

Given the dearth of objective documentation of dissociative symptoms and the antecedent abuse that engenders dissociative identity disorder, we welcomed the opportunity to present objective data on dissociation and abuse in 12 murderers suffering from the disorder. As will be discussed, we believe that our findings are also relevant to cases of the disorder in adults who have not committed violent crimes.

## METHOD

During a 13-year period in the 1980s and 1990s, the first author (D.O.L.) had the opportunity to do psychiatric evaluations of approximately 150 murderers. Of these murderers, 29 were subjects in a study of death row inmates. The majority of the rest were evaluated at the request of individual defense attorneys. Several others were evaluated at the request of the court, of prosecutors, or of family members. Of these murderers, 14 met the DSM-IV criteria for dissociative identity disorder. We were able to obtain objective documentation of both child abuse and long-standing dissociative signs and symptoms in 11 of these 14 individuals and of early dissociative signs and symptoms in a 12th. This report focuses on the 12 murderers with dissociative identity disorder for whom objective, confirmatory data on child abuse and/or long-standing dissociative symptoms could be verified. There were 11 men and one woman. Their ages at the time of their offenses averaged 28 years (range=15-44). Eight were white and four were black.

The subjects' psychiatric, neurologic, medical, social service, welfare, school, probation, police, prison, and military records were reviewed, and in eight cases social service, medical, psychiatric, military, court, or police records pertaining to parents were also reviewed. Any evidence of abuse, neglect, and/or dissociative signs and symptoms was noted and tabulated.

All 12 subjects had been evaluated psychiatrically by the first author (D.O.L.), a board-certified psychiatrist. Nine had been examined neurologically by one of the authors (J.H.P.), a board-certified neurologist; a 10th was examined by another board-certified neurologist. An 11th, at age 2, had been evaluated by a neurologist, at which time an EEG was performed. The psychiatric and neurologic reports of these evaluations were reviewed. The nature of the psychiatric and neurologic evaluations and the criteria for specific signs and

symptoms have been described elsewhere (22-25). During these psychiatric evaluations, dissociative phenomena were explored in detail and included questions about trances, time loss, fugues, amnesias, imaginary companions, rapid mood shifts, auditory/visual hallucinations, fluctuations in skills, being blamed for disavowed acts, sounding/acting like a different person, and using different names/signatures/handwriting. Records of these neuropsychiatric evaluations and of any previous evaluations were reviewed for the presence or absence of the above-mentioned signs and symptoms. Handwriting samples (e.g., old journals, letters) were also examined. These written materials were produced before the subjects' psychiatric evaluations and thus were not influenced by the examiner. In all cases, affidavits, testimony, and/or reports of interviews with family members, friends, neighbors, childhood acquaintances, teachers, probation officers, police, and clergy were reviewed for mention of the signs and symptoms and for any indications of abuse and neglect.

At the time of publication of this article, clinical data regarding symptoms and abuse histories were in the public domain (i.e., in trial transcripts, exhibits, appeals briefs, newspaper articles, and books); hence, informed consent to tabulate data was not necessary. Nevertheless, out of respect for the privacy of the subjects and their families, we have not identified the subjects by name.

## RESULTS

### *Signs and Symptoms of Dissociative Identity Disorder*

Table 1 presents the subjects' dissociative symptoms in childhood and adulthood and the corroborative documentation. Among the most common symptoms and signs were trances, amnesias for circumscribed periods of time and/or particular behaviors, changes in voice and demeanor, and auditory hallucinations.

As can be seen in table 1, the amounts of information available on the subjects' childhoods varied. We were able to obtain objective evidence that during childhood, eight of the 12 subjects had trances and amnesias, nine had experienced auditory hallucinations, and 10 had vivid and long-standing imaginary companions who seemed to be precursors of their alternate personality states.

Ten subjects experienced trance-like states in adulthood that were also observed by others. Two described their ability to remove themselves from situations as "astral projection." Others described their trance-like



abusive mother personality, one had a powerful aunt personality, and one had a sister personality. The nature and function of these alternate personalities and their relevance to the crimes committed will be described in a subsequent paper.

Table 1 lists the sources of information confirming evidence of dissociative identity disorder in each subject. As can be seen, documentation regarding subjects' dramatic changes of voice and/or demeanor came not just from family members but also from police records, notes of a legal assistant, observations of a jail guard, observations of a prosecution psychiatrist, and subjects' co-workers, roommates, acquaintances, and friends. As mentioned, objective documentation of personality changes in the form of different handwriting and signatures could also be found in the journals, letters, and documents of 10 subjects.

### *The Nature of Maltreatment in Childhood*

Because the histories of abuse of both patients with dissociative identity disorder and murder suspects are often questioned, we call special attention to table 2, which presents objective documentation of the nature and extent of physical and sexual abuse of 11 of our 12 subjects. The term "abuse" does not do justice to the quality of maltreatment these individuals endured. A more accurate term would be "torture." For example, subject 4 was deliberately set on fire by his parents. Subject 6 was used in child pornography by stepfathers and was deeply scarred from anus to mid-buttock from having been made to sit on a stove burner. At 3 years of age, subject 2 had his penis scalded and "circumcised" by his father. Subject 5 was tied down by his stepmother, given enemas allegedly containing blood, and, to stanch the blood, had tampons inserted into his rectum, thus simulating menstruation. This subject was removed from one foster family because he had been caught molesting other children and wearing girls' underwear and sanitary napkins.

We were surprised to find that in their usual personality states, most subjects denied or minimized childhood maltreatment. Four of them, for whom documentation of extraordinary abuse was discovered, totally denied any physical or sexual abuse. Seven others who had been severely physically and/or sexually abused had but fragmentary memories of the abuse. None attempted to use histories of abuse to enlist the sympathy of jurors or to excuse their violent acts. Since in their usual personality states most of the subjects had no idea of the kinds of maltreatment they had sustained, they could not use histories of abuse to manipulate clinicians or anyone else.

Histories of maltreatment were obtained primarily from old records, accounts provided by first-degree relatives, and the reminiscences of childhood friends. For example, subject 3 had no recollection of his incestuous relationship with his mother; information regarding incest was gleaned from the social service records of his brother. Similarly, subject 6 knew nothing of the

sexual abuse sustained at the hands of his grandparents. The affidavit of a cousin who lived with him during childhood—a document discovered by one of the authors (D.O.L.) after the subject had been executed—revealed that his grandmother had dressed him as a girl and given him to his grandfather to be used for sexual gratification.

Before evaluation none of the subjects was aware that he or she suffered from dissociative identity disorder, and most remained ignorant of their condition after their psychiatric evaluations. Even after some were told of their condition, they tended to disbelieve it. For example, when subject 4 learned of his diagnosis at a court hearing, his response was, "I think you're full of shit." Of note, in this case, because of his dramatically changing demeanor during incarceration, the subject's fellow prisoners had made the diagnosis of multiple personality disorder years before the psychiatrist ever saw him.

### DISCUSSION

Our ability to interview subjects' family members and friends, our access to their past psychiatric, social, and educational records, and our access to their personal letters and diaries enabled us to document evidence of long-standing dissociative symptoms in all 12 of our subjects and to obtain objective evidence of extreme abuse of 11 of them. Rarely, if ever, do psychiatrists have the opportunity to obtain this quantity and quality of confirmatory data about adults with dissociative identity disorder. It was only because of the time-consuming investigations conducted in the course of the legal representation of these murderers that we could amass these kinds of data.

Contrary to Dinwiddie and colleagues (18), we have demonstrated that dissociative identity disorder can be differentiated from malingering and other disorders. The evidence of strikingly different handwriting styles *antedating* the murders in question, plus the documentation of amnesias and of changes in voice, demeanor, and appearance observed by family members and others *before* our subjects' crimes, settles once and for all the issue of malingering in these cases. To have malingered, our subjects would have to have planned their murders long in advance and feigned their early symptoms in anticipation of some day committing a violent crime, a highly unlikely scenario. In short, with adequate data, it is possible to distinguish dissociation from malingering and from other disorders. For example, although dissociative identity disorder shares certain symptoms with schizophrenia, bipolar disorder, and other syndromes, none of these other disorders is characterized by the voice, demeanor, and handwriting changes and amnesias characteristic of dissociative identity disorder, as documented in our study group.

The question remains: to what extent are our 12 murderers with dissociative identity disorder representative of other adults with the disorder? After all, most pa-

TABLE 2. Nature and Documentation of Childhood Maltreatment of 12 Murderers With Dissociative Identity Disorder

Subject	Physical Abuse	Sexual Abuse	Documentation	Informants	Scars
1	Severe beatings by mother, father; tied up and beaten by mother; neglect	Sexual abuse by mother; incest with sisters	Trial testimony regarding father's incarceration for violence to his family; neglect petitions; mother declared unfit; children removed from home	Mother, sister, aunt	Head, back
2	Thrown into wall by father (ages 14 months and 3 years), causing indentation of skull; leg fractured by father (age 5); tied up naked and beaten by mother; set afire by siblings	Sexual abuse by father, including "circumcision" (age 3)	Childhood hospital records document numerous injuries, losses of consciousness, "seizures"; father's military records indicate court martial and dishonorable discharge for beating subject's 7-month-old sibling; father's medical records document fist traumas coincident with subject's unexplained injuries	Mother, brother	Head, back, chest
3	Severe beatings by mother, father; neglect	Sexual abuse by mother; incest with sister, brother	Neglect petitions; petition for termination of parental rights; brother's social work, welfare records reveal subject's incest with mother; school records report father's violence	Brother, childhood friend, neighbor, wife	Head, face, back, chest
4	Severe beatings by father; scalded by mother; set afire by parents	Sexual abuse, including sodomy with bizarre objects, by father; sexual abuse by older brother	Hospital records document several admissions starting at age 2 for "convulsions" and loss of consciousness; police reports call father "highly emotional and erratic"	Mother, father, brother	Head, back, chest, arms, thighs, buttocks, penis
5	Severe beatings by mother, father, stepmother; burned and thumbs pulled out of sockets by stepmother; locked in closets and basement by stepmother; abandoned by mother	Sexual abuse by stepmother, including sodomy with bizarre objects, being tied down and given blood enemas; dressed as a girl by stepmother	Child medical, psychiatric, and foster care records document abuse by father, mother, stepmother; mother declared unfit, children removed from home; police records document stepmother's violence	Mother, aunt, uncle, childhood friend	Head, back, chest
6	Severe beatings by mother, stepfathers, grandparents; burned by grandmother, stepfather; locked in basements and attics by grandmother; neglect	Sexual abuse by mother, grandparents; prostituted by stepfathers; dressed as a girl by grandmother	Removed from home by court order; social service records, juvenile probation records, parole records document family dysfunction; cousin's affidavit documents sexual abuse by grandparents	Mother, siblings, cousin, neighbors, teacher, two priests	Head, back, chest, buttocks; deep 2-inch burn from left buttock to anus
7	Daily severe beatings by father	None reported	Emergency room records report severe headaches beginning in third grade	Mother, father, childhood friend, aunt, maternal and paternal grandmothers	Head, face, back, legs
8	Locked in closet, hit on head with skillet by mother; beaten by father	Sexual abuse by mother, aunt	Child medical records indicate hospitalizations (ages 9 and 10) for hysterical paralysis	Mother (denied all abuse), wife, girlfriend	Back
9	None reported	Sexual abuse by father	Medical records of treatment for hysterical seizures	Father—refused to allow mother to be interviewed alone (parents denied abuse)	None noted
10	Beaten while naked with belt, switches, whips, until bleeding, by mother and her boyfriends; abandoned by mother	Suspected sexual abuse by father, grandfather, great-grandfather (slept with them in same bed and complained of frequent anal pain as a child); sexual abuse by aunt; incest with sister	Mother charged as unfit	Mother, aunt, childhood friends	Back

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TABLE 2 (continued)

Subject	Physical Abuse	Sexual Abuse	Documentation	Informants	Scars
11	Beatings by father with belts, extension cords, brooms	Sexual abuse by older male relatives	Child psychiatric records of treatment for excessive masturbation and problems relating to father	—	Chest, back, arms, legs
12	Severe beatings by mother (e.g., hit with wrenches, vases); father shot at mother—bullet grazed subject (age 5); beaten with belt and whip by uncle; neglect	Sodomized by older male relatives; sexual abuse by grandmother; given biweekly enemas by grandmother	Psychiatric hospital records, psychiatric outpatient records; social service records (age 6) report mother placed child with state because she was injuring him; nine reports of neglect and “possible sexual abuse” since age 1; court records; mother’s psychological reports/records	Mother, brother, mother’s friend	Chest, back, arms, ankles

tients with the disorder do not commit murder. On the other hand, most patients with the disorder do have aggressive, protector personality states (1, 5). However, relatively few commit violent crimes, reflecting, at least in part, the fact that most recognized cases of dissociative identity disorder occur in women (1, 26, 27), and women as a group are far less violent than men (28). Whereas Loewenstein and Putnam (26) reported that similar percentages of men and women among their subjects with multiple personality disorder had “homicidal alters” (35% versus 32%), 19% of the men and only 7% of the women reported actually having committed murder. In our own clinical experience, we found that among the male outpatients seeking treatment for dissociative identity disorder at our clinic, a substantial percentage (64%) had demonstrated rageful behaviors that came just short of homicide. In fact, one patient reported spending time in a reformatory after committing murder, and two others had been arrested for attempted murder. A much smaller percentage of the women in our clinic group (9%) were similarly aggressive. One had attempted to shoot her adult son, and another had tried to push her father in front of a car.

The majority of the males with dissociative identity disorder that we have seen have not been clinic outpatients but, rather, have been examined in prisons, where they were incarcerated for violent crimes. On the basis of our clinical experience, we suspect that the diagnosis of dissociative identity disorder is overlooked in males more often than it is in females because the violent behaviors of the protector alternate personality states of men go unrecognized and their violence is regarded instead as “sociopathy.” As a result, males with the disorder are far more likely than their female counterparts to be arrested and incarcerated.

The 12 murderers in our study were unaware of their psychiatric condition. They also had partial or total amnesia for the abuse they had experienced as children. Such is the nature of dissociative identity disorder. Contrary to the commonly held assumption that individuals facing the consequences of murder charges will exaggerate their childhood misfortunes, these murderers could barely remember anything about their childhoods. What is more, contrary to the popular belief that probing questions will either instill false memories or

encourage lying, especially in dissociative patients, of our 12 subjects, not one produced false memories or lied after inquiries regarding maltreatment. On the contrary, our subjects either denied or minimized their early abusive experiences. We had to rely for the most part on objective records and on interviews with family and friends to discover that major abuse had occurred.

Even if the subjects had been able to provide memories of maltreatment and even if they had been aware of their diagnosis, because we were dealing with two problematic issues—murder and dissociative identity disorder—it was vital that we document from outside sources as much objective evidence as possible of dissociative symptoms and childhood maltreatment. We did this. In every case, three or more outside sources provided independent evidence of subjects’ marked changes in voice, demeanor, and behavior, and in 11 cases abuse was also verified objectively. Furthermore, in 10 cases handwriting samples produced before the offenses in question documented changes in writing styles and signatures. Thus, the diagnosis of dissociative identity disorder and the history of abuse did not rest exclusively or even primarily on reports obtained from a subject.

The extent to which it was possible in these murder cases to review old records, interview families, and obtain objective documentation of symptoms and early abuse was, of course, unusual. In most cases of dissociative identity disorder, this degree of verification is not possible. Nevertheless, our experience with these 12 murder cases illustrates that with sensitivity, diligence, and appropriate resources, corroborative external evidence of prior dissociative symptoms and of early, extreme abuse in adult patients with dissociative identity disorder is there to be found. We may not always be able to obtain this extensive a body of documentation for all of our patients, but we must try.

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