
Rorschach Indicators of Dissociative Identity Disorders: Clinical Utility and Theoretical Implications



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The purpose of the present study was to replicate Rorschach signs of Multiple Personality Disorder (MPD) using DSM-IV criteria of Dissociative Identity Disorder (DID). Women admitted to either an inpatient dissociative disorder's unit ($n = 27$) or a general psychiatric unit ($n = 72$) were given the Rorschach, which was scored for the Labott, Barach, and Wagner Rorschach markers of MPD. Results indicated that Rorschach signs of the three different systems were significantly better than chance at classifying patients as DID or as non-DID. The Labott system, which performed the best, was able to accurately classify 92% of the sample. These results argue for the validity of the DID diagnosis. The Rorschach signs operate independent of external bias, yet correspond to the diagnoses obtained through psychiatric evaluation in an inpatient setting. The fact that two relatively rare sets of signs (DID and Rorschach) converge in the same small sector of the psychiatric population represents evidence of linkage that is clinically meaningful and not explainable on the basis of artificial creation. © 1998 John Wiley & Sons, Inc. *J Clin Psychol* 54: 803-810, 1998.

Studies of Rorschach characteristics of patients who meet DSM-III-R (American Psychiatric Association, 1987) criteria for the diagnosis of Multiple Personality Disorder (MPD) have led to the development of a number of measures for the clinical assessment of this disorder (Barach, 1986; Wagner, Allison, & Wagner, 1983). The newest of these diagnostic tools has come to be known as the Labott signs. Using the clinical criteria of DSM-III-R (American Psychiatric

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Association, 1987), patients diagnosed with MPD produced patterns of Rorschach response on two Labott signs that reliably differentiated them from other psychiatric patients (Labott, Leavitt, Braun, & Sachs, 1992). The sensitivity and specificity for the Labott signs were both 94%.

There are a number of reasons to cross-validate the findings. First, since the original publication, MPD has been renamed and the criteria for its diagnosis revised. Although the change of the name to Dissociative Identity Disorder (DID; American Psychiatric Association, 1994) will not affect the types of patients diagnosed, the addition of the criterion, "inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness" makes the diagnosis more restrictive and may eliminate some patients who would otherwise have been assigned the diagnosis.

Second, the Labott markers were developed with psychological testing limited to the host personality. Restriction of testing to the host personality may have created a somewhat artificial situation because subtle switching between personalities is widely accepted (Bryant, 1995; Putnam, 1984). The instructions may have eliminated some Rorschach responses that otherwise would have been generated by unidentified personalities switching with the host personality. Replication in a free test situation involving both the host and alter personalities is therefore desirable.

Finally, sensitivity and specificity rates of 94% with the Labott signs have important implications for the argument proffered by critics that DID is an artificially created diagnosis (McHugh, 1995; Merskey, 1992; Piper, 1994). These rates imply a significant conjuncture of two entirely different data sets in psychiatric patients carrying the diagnosis of DID. The manifest criteria of DID have been argued to be therapeutically implanted (McHugh, 1995). The other data set that simultaneously occurs with the manifest criteria are unobtrusive signs that are unknown to both patients and treaters and therefore cannot be shaped by iatrogenic effects. Co-occurrence is clearly specific to the DID population; the nonobtrusive signs are rarely found among other psychiatric conditions. In the Labott et al. study (1992), the nonobtrusive signs occurred in 94 cases per 100 among patients diagnosed with MPD, which constitutes only a small percentage of all psychiatric diagnosis (approximately 3%—see Figure 1). In patients not diagnosed with MPD, which constitutes the majority of all psychiatric disorders (approximately 97% of all

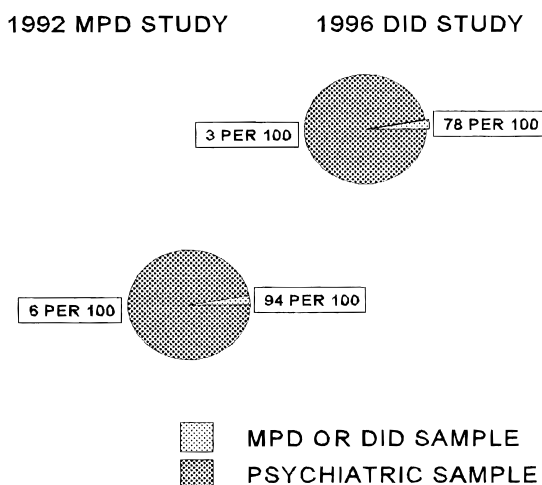


Figure 1. Prevalence of Labott signs in patients meeting DSM criteria for multiplicity in 1992 MPD study of 32 participants and 1996 DID study of 99 participants. With an estimated DID prevalence rate of 3% used to partition patients into DID/MPD and non-DID/MPD subgroups, 94% and 78% of DID patients demonstrated the Labott signs, whereas only 6% and 3% of the non-DID patients did so.

psychiatric diagnosis—see Figure 1), the Labott signs occurred in only 6 cases per 100. Replication of the sensitivity and specificity rates in a new sample would provide strong support for the validity of DID as an authentic diagnostic entity.

METHOD

Participants

Participants in the study were 27 women admitted to a Dissociative Disorders Unit who were referred for comprehensive psychological testing and who received a DSM-IV diagnosis of Dissociative Identity Disorder at discharge. The diagnoses were based on the clinical opinion of their attending psychiatrist, each with a high degree of experience and expertise in the area of dissociation. Diagnoses were recorded in patients' charts at the time of discharge and were obtained by independent examination of the chart after all other study data were entered into the computer file.

Participants in the control group were 72 women admitted to general psychiatric units of the same medical center who were referred for psychological testing during the same time period. Additional selection criteria for control participants included: (a) no neurological disorder, (b) no psychotic disorder, (c) no dissociative disorder, (d) aged 18 to 55 years, and (e) at least a high school education.

Procedure

The Rorschach Test was administered by a psychologist as one component of the evaluation process. Administration involved the traditional Free Association and Inquiry phases following standard Beck directions (Beck, Beck, Levitt, & Molish, 1961). Testing began with the host personality: the personality who presented most often (Braun, 1986). With this exception, there were no further efforts to limit participation by other alters. Switching was neither encouraged nor inhibited.

Labott Rorschach signs

1. Dissociation. The definition of dissociation was adapted from the previous work of Labott, Leavitt, Braun, and Sachs (1992); Leavitt and Labott (1996); and Saunders (1991). Responses were counted as dissociative if they fulfilled one of the following criteria:
 - (a) Reference to forms seen through obscuring media such as veils, fog, or mist so that people or objects appear unclear, blurry, or unreal. Sample responses included people surrounded by clouds or walking in mist, ghost-like shadows of people, figures all fogged up or forming from smoke, a face losing its shape by dissolving into gray, distorted images that appear as though viewed through a rain-soaked window, or a city buried in layers of clouds that cast different shadows. Content limited to smoke, clouds, or fog is not scored.
 - (b) Reference to unusual responses in which distance appears exaggerated such that objects or figures appear vague and far away from other specified objects. Perceptual vagueness goes beyond reduction in size caused by distance such as landscape viewed from an airplane. Sample responses included objects viewed as though looking through something that is very deep and blurry and figures appear to be far away, people viewed as though looking into a gaseous canyon at objects far below, a skull observed at a distance hidden behind ominous-looking clouds, a castle covered

by a bubble observed at a distance (the colors inside the bubble are faded as in a magic land).

- (c) Reference to a sense of disorientation in which Rorschach stimuli are experienced as unstable, shifting, moving, or rapidly changing. These are unusual and exaggerated distortions of response caused by the perception of motion in the test stimuli that go beyond the usual fires, explosions, and volcanic eruptions. Sample responses included clothing of people pulled backward by the force of a terrible windstorm, a tornado blowing everything apart with debris flying everywhere, and objects moving in a spiral weaving back and forth in the air.

2. Split. References to the experience of fragmentation in the form of split or pulled-apart human images are counted (Labott et al., 1992). Sample responses included a woman splitting in two (she was cut down the middle but was trying to hold together); a person torn to pieces, with hardly any connections to what used to be the body although tiny lines were still trying to make the body come back together; a person splitting off and separating in different directions.

Reference to abstract and nonhuman images being broken, divided, or split were also counted in the original study. They did not add to the discriminatory power of the human split response in the original study and thus were eliminated as criteria in this study. According to Labott, at least one dissociative and one split response are necessary for the diagnosis of MPD/DID (Labott et al., 1992).

In addition to replicating the Labott signs, we also examined the discriminant validity of two other Rorschach measures used in the original study: the Wagner and Barach signs.

Wagner signs. According to Wagner, five Rorschach signs are necessary for the diagnosis of MPD/DID (Wagner et al., 1983; Wagner & Heise, 1974; Wagner, Wagner, & Torem, 1986).

1. At least six movement responses ($M + FM + m$).
2. At least two human movement responses are qualitatively diverse (e.g., man is conducting an orchestra vs. man is destroying an object).
3. At least one movement response reflects feeling of oppression (e.g., man is hitting a child).
4. At least three color responses and $C + CF > FC$.
5. At least one color response is positive (e.g., red bow tie) and another is negative (e.g., blood).

Barach signs. According to Barach, at least two hiding and denial response are necessary for the diagnosis of MPD (DID; Barach, 1986).

1. Denial responses. During inquiry, the participant either (a) denies something reported in free association, (b) has trouble locating something reported during free association, or (c) confabulates to explain a percept reported in the Free-association phase.
2. Hiding responses. During either the Free-association or Inquiry phases, (a) something in the blot is said to be hiding behind something else, appearing from behind something else, or appearing from within another part of the blot; (b) something in the blot is unaware of something else in the blot; or (c) a mask is seen in the blot.

RESULTS

Demographics

A *t*-test was run to compare ages in the two groups. The result was not significant, indicating that the two groups were similar in age (DID: $M = 36.11$, $SD = 6.13$; Control: $M = 36.83$, $SD = 11.05$). Years of education in the two groups were compared accordingly; the *t*-test was also nonsignificant in this case (DID: $M = 14.11$, $SD = 2.24$; Control: $M = 13.86$, $SD = 2.14$).

Reliability

Adequate interrater reliability was established for Rorschach study variables between the first and second author in previous studies (Labott et al., 1992; Leavitt & Labott, 1996). Authors were blind to discharge diagnosis.

Group Differences

Because the number of responses given by participants could influence the occurrence of various signs, the two groups were compared on the total number of Rorschach responses using a *t*-test. No significant differences occurred (DID: $M = 39.60$, $SD = 9.95$; Control: $M = 36.89$, $SD = 10.05$).

Chi-square analyses were next performed to compare the frequency of DID and Control diagnoses in the two groups using the three methods of diagnosis described previously. For all three diagnostic systems, the chi-square values were significant (Labott: $\chi^2(1, n = 99) = 61.93$, $p < .0001$; Barach: $\chi^2(1, n = 99) = 27.97$, $p < .0001$; Wagner: $\chi^2(1, n = 99) = 33.73$, $p < .0001$). Therefore, for all three systems, the diagnostic signs did significantly better than chance at predicting group membership.

The frequency of obtained diagnoses was then examined more thoroughly. Results of the classification of subjects as either DID or Control for all three systems are shown in Table 1. With respect to the Labott signs, it can be seen that 21 of the 27 DID patients were correctly classified as DID, for a sensitivity rate of 78%. Conversely, 70 of the 72 controls were correctly classified, for a specificity rate of 97%. Overall, 92% (91 of 99) participants were accurately diagnosed using this system.

Table 1. Classification of Patients Using Labott, Barach, and Wagner Systems

Predicted diagnosis	Actual diagnosis	
	DID	Control
A: Labott signs		
DID	21	2
Control	6	70
B: Barach signs		
DID	17	8
Control	10	64
C: Wagner signs		
DID	18	7
Control	9	65

Next, the Barach signs were examined in a similar manner (see Table 1). This system obtained a sensitivity rate of 63% (17 of 27) and a specificity rate of 89% (64 of 72), for an overall correct classification rate of 82%.

Finally, the same analysis was performed using the Wagner signs to assign participants to either the DID or control groups. Also in Table 1, it can be seen that 67% (18 of 27) sensitivity and 90% (65 of 72) specificity were obtained, with an overall correct classification of 84%.

DISCUSSION

The results of the replication study provide strong support for the validity of the Labott signs as Rorschach indicators of Dissociative Identity Disorder. The two signs were highly accurate in classifying patients as either DID or non-DID. This occurred in a much larger patient sample than in the previous study ($N = 32$ vs. $N = 99$). They correctly identified 91 out of 99 patients for an accuracy rate of 92%. The sensitivity rate (percentage of true cases by expert opinion classified as DID-positive by criteria) was 78%; the specificity rate (percentage of non-DID cases classified as DID-negative by criteria) was 97%. This means that the Labott signs are most accurate for classification of patients with non-DID-diagnosed psychiatric disorders. The error rate for this group was 3%. This means that only 3 patients per 100 will be misclassified as DID. By contrast, the error rate for DID patients was 22.2%. This means that one DID patient in five will not be detected by the Labott signs. These cases may simply be false negatives or a specific DID subtype that warrants further investigation.

Data from the Wagner and Barach signs were also diagnostically informative. Their accuracy rates of 84% and 82%, respectively represent a major increase in accuracy from the initial study (Labott et al., 1992). These signs are considerably less prevalent in the general psychiatric population than was inferable from the initial study of 16 psychiatric patients with non-DID Axis I disorders. One possible reason for the difference may be a change to the Beck method of Rorschach administration, which produces a shorter record. Non-DID cases, on average, produced six less responses with this method of administration. The results of the earlier study may be an artifact of response size because the Barach and Wagner signs are response sensitive. For example, it is easier to meet Wagner criteria of 6 movement responses in a 40-response record than it is in a 30-response record. It may well be that both the Wagner and Barach signs are more diagnostically sensitive with shorter Rorschach protocols.

The point of view that DID is an iatrogenic creation has several implications. One is that DID is not a true psychiatric disorder. Another is that patients carrying the diagnosis have been mislabeled through therapeutic error and belong to other psychiatric categories. However, the present findings run strongly counter to these views. The particular set of symptoms that serves to justify the clinical diagnosis of DID is found in only a small percentage of the psychiatric population. Although the prevalence of DID in psychiatric populations is still open to debate, the most frequently cited data-based estimates are in the 1% to 5% range; our working estimate is 3% (Graves, 1989; Putnam, Loewenstein, Silberman, & Post, 1984; Ross, 1987; Ross, Anderson, Fleisher, & Norton, 1991; Saxe et al., 1990). The dissociative and split Rorschach signs are also found in combination in a small percentage of the general non-DID psychiatric population: approximately 3%. The fact that two relatively rare sets of criteria converge in the same, small sector of the psychiatric population can be taken as evidence that they are meaningfully interlinked. Approximately 3 in 100 psychiatric patients produce the Labott signs; however, three out of four who meet the diagnostic criteria of DSM-IV produce them (see Figure 1). Thus, patients who meet the defining manifest criteria for DID have a significant communality with each other on subclinical measures that are uncommon in other psychiatric populations. Psychiatric patients not part of the DID population do not share the Labott Rorschach signs. In this sense, DID shows the homogeneity of a diagnostic entity with defining features that are distinct

from other psychiatric disorders. These findings support Putnam's contention "that a specific, unique, and reproducible clinical syndrome is being described" by DID (Putnam, 1995, p. 961).

The co-occurrence of DID DSM-IV criteria and Labott Rorschach signs does not appear to be random or explainable on the basis of artificial creation. The subclinical Labott signs shared by this small population cannot be suggested, implanted, or approximated because they operate outside of conscious awareness and are not intuitively obvious to either patients or treating clinicians. Patients entering psychological examination do not have foreknowledge of the salient Rorschach patterns. As such, the Labott signs appear to function independently from presumed external bias and add important information to the clinical database, particularly in cases where DID is suspected but not confirmed and in cases complicated by personality factors. Because the study has important clinical implications, replication in nonhospitalized patients would appear to be warranted.

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