

# ON THE MISDIAGNOSIS OF MULTIPLE PERSONALITY DISORDER

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## ABSTRACT

*In many mental health settings, there has been an increasing awareness that multiple personality disorder (MPD) is far from rare. However, along with this awareness has come an increased incidence of the misdiagnosis of MPD. The misdiagnosis of MPD (i.e., false positive diagnosis of MPD) has been seen in three forms: other dissociative disorders, non-dissociative disorders, and malingering or factitious disorders misdiagnosed as MPD. The accurate differential diagnosis of MPD can be challenging, but has important clinical implications.*

## INTRODUCTION

In recent years, both clinical experience and reports in the scientific literature have suggested that multiple personality disorder (MPD) is far more common than previously believed (Greaves, 1980; Bliss, 1980; Kluft, 1984; Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons, Bowman, & Milstein, 1988; Putnam, 1989; Ross, 1989; Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990). In fact, two recent research reports have suggested that dissociative experiences in the range of multiple personalities (Chu & Dill, 1990), and multiple personality disorder as diagnosed by structured interview (Ross, Anderson, Fleisher, & Norton, 1991) have a prevalence of approximately 5 percent in inpatient psychiatric populations. In the past, lack of awareness of dissociative phenomena led to MPD being under-diagnosed as documented by Putnam et al. (1986), who reported an average of more than six years between first contact with the mental health system and the diagnosis of MPD. Now there is increasing recognition that multiple personality disorder is far from rare. However, this increasing acceptance has led to other conditions being misdiagnosed as MPD.

The misdiagnosis of MPD — that is, the false positive diagnosis of MPD — seems to fall into three major categories: patients with other dissociative or trauma-related disorders, patients with no dissociative disorder but other major psychiatric disorders, and patients with factitious disorders or who are malingering. This discussion is based on several hundred cases of reported MPD over a ten-year period, many of whom were seen on an inpatient basis. Most reported

cases of MPD were, in fact, verified as MPD by experienced clinicians. A number of cases were found to be more appropriately understood as suffering from other dissociative disorders or another kind of disorder. Only five cases were seen where it became clear that there was malingering or a factitious disorder. Although misdiagnosis of MPD is uncommon, it is of clinical significance for an increasing number of patients.

## OTHER DISSOCIATIVE DISORDERS MISDIAGNOSED AS MPD

The concept of a dissociative continuum has been suggested by Braun (1986), Bernstein and Putnam (1986), and others, in which it is believed that an individual's dissociative experiences may range from normal to pathological. The most severe dissociative experiences are found in persons with post-traumatic stress disorder and dissociative disorders. However, only a minority of patients with severe dissociative symptoms actually have multiple personality disorder. In two studies (Chu & Dill, 1990; Ross et al., 1991), approximately one-quarter of inpatient populations were found to have levels of dissociation consistent with a dissociative disorder, versus approximately only 5 percent with possible MPD. These findings reflect clinical observations that there are many patients with dissociative disorders who do not have full-blown MPD. Many of these patients have severe dissociative experiences, including a fragmented sense of self, but do not have true multiple personalities. Such patients often describe feeling as though they are different people at different times, or that they watch themselves doing things almost as if they were outside their own bodies. Watkins and Watkins (1979) described such patients as having varying "ego-states" in which they have clear changes in their sense of identity, but do not necessarily have the extreme dissociative barriers of MPD. It is these kinds of patients that can be easily confused with patients with MPD.

One problem in making accurate diagnostic assessments with patients with dissociative disorders is that the level of dissociative symptomatology is somewhat variable for many patients. For example, some patients with severe dissociative symptoms may manifest more florid symptoms under conditions of stress, sometimes to the extent of demonstrating transient but clear multiple personalities. Braun (1986, p. 20) labels such patients as having atypical MPD and notes: "In atypical MPD, the patient initially may not appear to have multiple personalities at all. ... Under sufficient stress, the atypical MPD patient will decompensate and present as a typ-

ical MPD patient." Such patients do not consistently meet criteria for MPD as in the following example:

A 25-year-old woman with a known history of childhood physical and sexual abuse, as well as symptoms of post-traumatic stress disorder, was admitted to the hospital after being mugged on the street in her neighborhood. While in the hospital, she showed evidence of three separate personalities, including a depleted host personality, a child personality, and an angry persecutor personality. She worked actively on issues related to the mugging and on how to maintain personal safety, and was discharged in two weeks. On follow-up one month later, she was asked about the various personalities. She answered, "Well, they're all a part of me now," and her outpatient therapist confirmed that there was no continuing evidence of separateness.

The misdiagnosis of MPD also occurs in situations where patients with dissociative disorders (but do not have clear MPD) consciously or unconsciously exaggerate their dissociative symptoms. Many true MPD patients present without clear evidence of multiplicity and then go on to demonstrate unambiguous personality fragmentation. However, there are situations in which patients report a greater degree of internal fragmentation than actually exists. This has been particularly true in inpatient settings where MPD and other dissociative disorder patients are hospitalized together. In these settings, patients without MPD, but who do have ego-state phenomena, may begin to take on characteristics of MPD which they see in others, perhaps as a way of trying to organize and express their own internal experience. In addition, the sometimes dramatic nature of MPD may make it seem like a more appealing identity rather than just simply having poorly defined dissociative experiences.

Over-enthusiastic mental health professionals and, sometimes, family members are also responsible for inducing a kind of pseudo-MPD in susceptible patients. There is considerable evidence against the possibility of complete iatrogenesis of MPD (Braun, 1984; Ross, Norton, & Fisher, 1989), especially in non-dissociative disorder patients. This view is bolstered by the observation that there is not a single reported case of *de novo* MPD produced in adults who were kidnapped, held hostage, tortured, or subjected to other severe trauma. However, there is significant clinical evidence which suggests that even subtle inducements by clinicians in patients who *already* have severe dissociative symptoms can push patients to appear more fragmented. Fascination with MPD is a common counter-transference response (Kluft, 1989), and such practices as therapists insisting on meeting a parade of personalities, naming personalities or ego-states, and/or treating personalities or ego-states as if they were indeed separate persons, increase internal dissociative barriers and sense of separateness. The following is an example of this kind of pseudo-MPD:

A young woman with reported MPD was interviewed during her hospitalization. The interviewer was struck

by the ease with which she talked about her multiple personalities and their characteristics, which was not his usual experience with most MPD patients. Although the patient did have some evidence of dissociative symptoms, the patient's "switching" and state changes did not seem at all like MPD. When asked why she thought she had MPD, the patient responded, "I've always had the sense that I was very different at different times. I was put on a unit for personality disorders, so I must have multiple personalities. I really enjoyed naming them all one night last week." When the interviewer asked if the patient knew about the correlation of early childhood trauma and MPD, and asked if the patient had such a history, she replied, "I don't remember any abuse, but they tell me that most people don't remember their abuse, and that this *proves* that I was abused."

## NON-DISSOCIATIVE DISORDERS MISDIAGNOSED AS MPD

Until recently, MPD was frequently misdiagnosed as other disorders (Putnam, et al., 1986), accounting for lengthy periods of fruitless treatment. Clinically, MPD was frequently misdiagnosed as a psychotic disorder due to psychotic-like symptoms such as auditory hallucinations and other "classic" psychotic symptoms (Kluft, 1987a). Frequently, lability of mood and personality switching of MPD were mistaken for rapid cycling bipolar disorder. Many such patients, when seen by clinicians experienced in the diagnosis and treatment of dissociative disorders, ultimately were diagnosed as having MPD.

Paradoxically, in recent years there has been an increasing number of patients with reported MPD who turn out to actually have a psychotic disorder or severe mood disorder. In some patients, the belief that they have MPD proves to be completely delusional, as in the following example:

A woman in her mid-thirties was admitted to a dissociative disorders unit with a provisional diagnosis of MPD. She reported numerous internal personalities, and did seem to manifest some evidence of switching, although clear personalities were not seen. She seemed mildly hyperactive, quite pressured in interpersonal settings, and slept only about one or two hours per night. The patient had a history of excellent premorbid functioning and good relationships, friends and family. There was some evidence of early family disruption, but no amnesia and no reports of abuse. The patient's attending physician suspected mania and recommended a trial of lithium. Within ten days, the patient was receiving a therapeutic dosage of lithium. All her symptomatology remitted, including the multiple personality phenomena. At a six-month follow-up, she continued to do well.

Some other cases are much less clear. Since it now appears that dissociative disorders are relatively common in psychiatric populations, it is certainly possible that patients may

have both a dissociative disorder and some other psychiatric disorder. In such situations it is difficult to assess the nature of the dissociative disorder until the mood or psychotic disorder is resolved. In general, clinical experience has suggested that a mood or psychotic disorder which co-exists with a dissociative disorder may increase dissociative symptomatology, as in the following example:

A 43-year-old woman was admitted to the hospital with the diagnoses of MPD and post-traumatic stress disorder. In addition to having many reported personalities, the patient related a long history of sexual abuse by a wide variety of people in her life, including family, acquaintances, even therapists, and other professionals with whom she had been involved. In the milieu, the patient appeared extremely labile in mood, at times almost euphoric, and other times extremely irritable and explosive. She seemed very mistrustful of others, but finally confided in one of the nurses that she was being raped by several members of the night staff on a regular basis. The diagnosis of atypical psychosis was made, and the patient was placed on anti-psychotic and mood-stabilizing medication. Within two weeks, the patient appeared calmer, and was able to realize that she was not being currently harmed by hospital staff, and had not actually been harmed by some of the people in her past who she had believed were abusive. She showed no evidence of MPD. However, she still reported early childhood abuse, and had a moderate level of dissociative symptoms consistent with post-traumatic stress disorder.

#### **MALINGERING OR FACTITIOUS DISORDERS MISDIAGNOSED AS MPD**

With the increasing availability of information concerning MPD in the media, in the scientific literature, and through patient networks and self-help groups, the possibility and incidence of deliberate simulation of MPD is increasing. Although this problem appears to be more frequent as malingering in the forensic setting where the motivation is obvious, it is also appearing in the non-forensic clinical setting as a factitious disorder.

Several discussions of this particular differential diagnosis appear in the literature (Orne, Dinges, & Orne, 1984; Watkins, 1984; Kluft, 1987b; Brick & Chu, 1991). In brief, the deliberate and realistic simulation of MPD over a brief period of time is not difficult. Clinicians need to be clear that the diagnostic criteria are met, and that commonly associated features of MPD such as those described by Putnam et al. (1986) are present. Kluft (1987) has suggested that MPD malingerers often were not convincing, particularly with inability to sustain consistent alternate personalities over time, little evidence of dividedness in the distant past, and few histories of unsuccessful prior treatments. He also found malingerers had stereotyped good/bad personalities and tended to "play up" their symptoms (p. 112). Finally, Brick & Chu (1991) have suggested that the availability of information

concerning MPD is an important consideration when making a differential diagnosis between true and simulated MPD.

Some malingering MPD may be relatively obvious, as in the following clinical example:

A 29-year-old male inpatient was evaluated for reported MPD. He reported no problems in childhood or adulthood prior to a traumatic accident two years previously. In this accident, he nearly drowned after his car went out of control and into a river. He survived on the air in the car, but was unconscious by the time he was rescued. In the interview, the patient alleged that a part of him had no memory of the accident ("My doctors told me it was too traumatic for me"), while another split-off personality had good recall. When asked about this other personality, he "switched," and with great drama described the accident and its aftermath, including his dying, being taken to the hospital, then to a morgue, being embalmed, and seeing his family mourn him. When the interviewer interrupted and asked if he felt that all these things actually happened, the patient irritably acknowledged that he was "imagining" what might have happened. When given the Dissociative Experiences Scale (Bernstein & Putnam, 1986), he had an extremely high score. However, none of these reported dissociative experiences were observed by others on the inpatient unit. In addition, there were clear inconsistencies in his reporting of various items (e.g., severe dissociation on one item versus none on another). It was subsequently discovered that there were numerous legal proceedings pending against the patient due to some questionable financial practices. It was strongly felt that this patient was malingering MPD.

Other cases of malingering of MPD or a factitious disorder may require an extended period of evaluation prior to accurate diagnosis, as in the following example:

A 32-year-old woman was admitted to an inpatient unit with reported MPD, post-traumatic stress disorder, and severe substance abuse. Her history was significant for severe childhood physical and sexual abuse, chaotic relationships, and numerous crises and hospitalizations throughout her adult life. She reported numerous ongoing dissociative symptoms, including "blackouts," and the existence of six alternate personalities, including depressed, suicidal, angry, and child personalities. On the unit, the nursing staff was skeptical about the validity of MPD diagnosis as her "personalities" appeared contrived, and her post-traumatic symptoms occurred only when convenient for her. It was felt that it would not be productive to question the patient's multiplicity, particularly since the major therapeutic emphasis was on the control and treatment of her substance abuse. The patient was quite angry about this emphasis on what she considered a secondary problem. She was

eventually discharged, but was re-admitted several months later after a near fatal drug overdose taken while she was intoxicated. At this point, the patient decided to "come clean" and admitted to fabricating the entire history of trauma and dissociation in an effort to avoid confronting her substance abuse. She described how she continued to take drugs throughout her previous admission, and how she consciously adopted the stories and symptoms of other patients she had met during the course of her treatment.

## CONCLUSIONS

The accurate differential diagnosis of MPD has obvious major clinical importance. Even in cases where the more appropriate diagnosis is a related dissociative disorder, there are often major clinical issues to be addressed. Although it may be legitimately argued that the treatment of MPD and closely related dissociative disorders is similar, the misdiagnosis of MPD often suggests major problems in the direction of treatment. It is always a clinical problem when patients, family members, or clinicians are encouraging more fragmentation rather than less. In fact, this essentially reinforces the basic psychopathology, where stress is managed by psychological distancing through dissociation. Good and effective clinicians must be able to acknowledge the extent of existing dissociation and personality fragmentation (e.g., the existence of MPD or ego-states). However, clinicians should never reinforce additional fragmentation (e.g., paying special attention to certain personalities or ego-states, or colluding with the creation of new personalities or ego-states). Rather, clinicians must acknowledge the extent of dissociative phenomena, and help patients to gradually move to states of less fragmentation and more integration.

In situations in which patients, rather than therapists or family members, are pushing themselves toward a greater degree of dissociation, this must be confronted as a serious problem. Patients' experiences of the dissociative, post-traumatic, and relational effects of severe childhood trauma are often confusing, chaotic, and often simply miserable. It may seem an attractive alternative to be a member of a group of patients with a dramatic and interesting disorder such as MPD. However, in the long run, this fixes patients in a position which is therapeutically untenable, and which offers little opportunity for successful resolution of either their psychopathology or the distress in their lives.

When other non-dissociative disorders are misdiagnosed as MPD, there cannot be effective treatment for the primary disorder. In cases where non-dissociative disorders co-exist with dissociative disorder, the non-dissociative disorder should often be the primary focus of treatment. This is particularly true in situations where patients have mood disorders, substance abuse, or some psychotic disorders. It is unlikely that patients' dissociative problems can be effectively addressed while they are undergoing the stress of these other conditions.

Finally, even when the appropriate diagnosis is malingered or a factitious disorder, underlying problems must

be addressed. As Orne et al. (1984) note, even when a patient is simulating a dissociative disorder, the patient is deserving of treatment, and "it is the therapist's responsibility to help the patient understand what he is doing, and to cope with the stressors that have made it necessary for him to act in this fashion" (p. 164). Good clinical care for many patients with reported MPD begins by clinicians critically examining the presenting symptoms, correctly understanding the biologic and psychological determinants of the symptoms, and making a careful differential diagnosis concerning MPD. ■

## REFERENCES

- Bernstein, E.M., & Putnam, F.W. (1986). Development, reliability, and validity of dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727-734.
- Bliss, E.L. (1980). Multiple personalities: A report of 14 cases with implications for schizophrenia and hysteria. *Archives of General Psychiatry*, 37, 1388-1397.
- Braun, B.G. (1986). Issues in the psychotherapy of multiple personality disorder. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 1-28). Washington, DC: American Psychiatric Press.
- Braun, B.G. (1984). Hypnosis creates multiple personalities: Myth or reality. *International Journal of Clinical and Experimental Hypnosis*, 32, 191-197.
- Brick, S.S. & Chu, J.A. (1991). The simulation of multiple personalities: A case report. *Psychotherapy*, 28, 267-272.
- Chu, J.A., & Dill, D.L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry*, 149, 887-893.
- Coons, P.M., Bowman, E.S., & Milstein, V. (1988). Multiple personality disorder: A clinical investigation of 50 cases. *Journal of Nervous and Mental Disease*, 176, 519-527.
- Greaves, G.B. (1980). Multiple personality: 165 years after Mary Reynolds. *Journal of Nervous and Mental Disease*, 168, 577-596.
- Kluft, R.P. (1984). Treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America*, 7, 9-29.
- Kluft, R.P. (1987a). First-rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry*, 144, 293-298.
- Kluft, R.P. (1987b). The simulation and dissimulation of multiple personality disorder. *American Journal of Clinical Hypnosis*, 30, 104-118.
- Kluft, R.P. (1989). The rehabilitation of therapists overwhelmed by their work with multiple personality disorder patients. *DISSOCIATION*, II, 244-250.
- Orne, M.T., Dinges, D.G., & Orne, E.C. (1984). On the differential diagnosis of multiple personality disorder in the forensic setting. *International Journal of Clinical and Experimental Hypnosis*, 32, 118-169.

Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 cases. *Journal of Clinical Psychiatry*, 47, 285-293.

Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford.

Ross, C.A. (1989). *Multiple personality disorder: Diagnosis, clinical features, and treatment*. New York: John Wiley & Sons.

Ross, C.A., Anderson, G., Fleisher, W.P., & Norton, G.R. (1991). The frequency of multiple personality disorder among psychiatric inpatients. *American Journal of Psychiatry*, 148, 1717-1720.

Ross, C.A., Miller, S.D., Reagor, P., Bjornson, L., Fraser, G.A., & Anderson, G. (1990). Structured interview data on 102 cases of multiple personality disorder from four centers. *American Journal of Psychiatry*, 147, 596-601.

Ross, C.A., Norton, G.R., & Fraser, G.A. (1989). Evidence against the iatrogenesis of multiple personality disorder. *DISSOCIATION*, II, 61-64.

Watkins, J.G. (1984). The Bianchi (L.A. Hillside Strangler) case: Sociopath or multiple personality? *International Journal of Clinical and Experimental Hypnosis*, 32, 67-101.

Watkins, J.G., & Watkins, H.H. (1979). The theory and practice of ego-state therapy. In H. Grayson (Ed.), *Short-term approaches to psychotherapy* (pp. 176-220). New York: Human Sciences Press.