MPD, BORDERLINE PERSONALITY DISORDER AND SCHIZOPHRENIA: A COMPARATIVE STUDY OF CLINICAL FEATURES

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ABSTRACT

Multiple personality disorder (MPD) has at times been confused with both schizophrenia (SCHIZ) and borderline personality disorder (BPD). In this study, 38 patients with DSM-III-R diagnosis of MPD (N = 16), SCHIZ (N = 11), or BPD (N = 11) were evaluated with a battery of structured interviews (SCID, DDIS) and psychometric tests (MMPI, MCMI, DES) in order to define distinguishing features among the three diagnostic groups. MPD was differentiated from SCHIZ on the great majority of test measures. MPD was not differentiated from BPD on MMPI or MCMI, but these groups differed in many clinical features, particularly measures of severity of abuse and dissociative symptoms.

INTRODUCTION

Multiple personality disorder (MPD) historically has been subsumed within the boundaries of other major psychiatric disturbances (Bliss, 1980; Greaves, 1980; Rosenbaum, 1980; Coons, 1984; Putman, Guroff, Silberman, Barban, & Post, 1986; Kluft, 1987; Horevitz & Braun, 1984; Clary, Burstin, & Carpenter, 1984). In the nineteenth century it was both understood and disputed in terms of its relation to hypnosis; subsequently it was understood as a manifestation of hysteria (Bliss, 1980; Greaves, 1980). More recently, MPD has been included within the diagnosis of schizophrenia (Bliss, 1980; Rosenbaum, 1980) and most recently the borderline conditions (Horevitz & Braun, 1984; Clary, et al., 1984). Until the recent development of DSM-III (and DSM-III-R), with its strict set of criteria for MPD, borderline personality disorder and schizophrenia, it has been difficult to determine to what extent our efforts to establish diagnostic classifications for these three diagnostic groups have represented careful study of homogeneous patient groups. The present research compares groups of patients with the diagnosis of multiple personality disorder, borderline personality disorder, and schizophrenia. In order to identify and define similarities and differences, the traits of these groups were measured using an extensive battery of diagnostic interviews and psychometric instruments. The hypothesis to be tested is that MPD represents a unique clinical entity, with stable and measurable clinical characteristics, which differentiate it from both schizophrenia and borderline personality disorder.

MULTIPLE PERSONALITY DISORDER AND SCHIZOPHRENIA

The relatively low prevalence of MPD in relation to schizophrenia, as well as the power of the Bleulerian and Schneiderian conceptualizations of schizophrenia, have resulted in the frequent misdiagnosis of dissociative pathology as schizophrenia. In a review of 100 cases of MPD, Putnam, Guroff, Silberman, Barban, and Post (1986) found that 49% had received a prior diagnosis of schizophrenia. Rosenbaum (1980), in a review of reported cases of MPD between 1903 and 1978, noted a dramatic decline in the reports of MPD after the new diagnosis of "schizophrenia" based on Bleuler's ideas became a mainstay of psychiatric diagnosis. Rosenbaum contends that after the introduction of this new diagnostic entity, the incidence of MPD declined as these patients were now more often diagnosed as having schizophrenia. Within the Bleulerian schema, however, MPD would be misconstrued as schizophrenia primarily on the basis of auditory hallucinations and associated findings, rather than on the core features of associative loosening, affective blunting, autism, and ambivalence. Schneider's eleven First Rank Symptoms (FRS) were an effort to establish greater diagnostic reliability for schizophrenia, and were to be considered pathognomonic for the disorder in the absence of organicity (Schneider, 1959). Recently, however, the specificity of the first rank symptoms has been refuted. Their occurrence has been demonstrated in a number of psychiatric conditions. Andreason and Akiskal (1983) have noted the high occurrence of FRSs in patients with affective disorders. Carpenter, Strauss, and Muleh (1973) have also noted the lack of diagnostic specificity in the Schneiderian FRSs and have found that they are reported in 20 to 50% of cases of manic depressive illness.

Kluft (1987b) has described the prevalence of First Rank Symptoms in patients with MPD. In his review of initial contacts with thirty MPD patients, he found that they endorsed an average of 3.8 Schneiderian symptoms. Each patient

endorsed from one to eight symptoms with a total of 108 FRSs endorsed in all. The eight Schneiderian symptoms endorsed were: (1) voices arguing, (2) voices commenting on one action, (3) influences playing on the body, (4) thought withdrawal, (5) thought insertion, (6) made feelings, (7) made impulses, and (8) made volitional acts.

Other investigators, while specifically reviewing neither Bleuler's criteria nor Schneiderian first rank symptoms in MPD patients, have noted considerable symptom overlap between schizophrenia and MPD. Bliss (1980), in a report of fourteen cases of MPD, found that 64percent heard voices, 36% saw visions, 73% felt that someone was trying to influence their minds, 55% experienced someone controlling their mind, and 27% had thought broadcasting. Putnam et al. (1986), in a review of the clinical phenomenology of 100 cases, found auditory hallucinations in 30%, visual hallucinations in 28%, apparent delusions in 21% and apparent thought disorder in 19%. Given the high rate of endorsement by MPD patients of Schneiderian FRSs and other symptoms frequently associated with schizophrenic illness, the potential for confusion between schizophrenia and MPD is readily apparent.

MULTIPLE PERSONALITY DISORDER AND BORDERLINE PERSONALITY DISORDER

Like schizophrenia, borderline personality disorder (BPD) has been a diagnostic group with an evolving degree of clinical specificity (Perry & Klerman, 1978; Gunderson & Kolb, 1978; Spitzer, Endicott, & Gibbon, 1979; Liebowitz, 1979; Lerner, Sugarman, & Gaughran, 1981; Kroll, Martin, Lari, Pyle, & Zander, 1981; Andrulonis, Glueck & Strobel, 1982; Clarkin & Widiger, 1983; Frances & Clarkin, 1984; Akiskal & Chen, 1985). Despite an abundant literature on "borderline" states, it was only with DSM-III that clear diagnostic distinctions were made between the borderline and schizophrenic conditions. While the subsequent distinction between schizophrenia and borderline personality disorder has been effected relatively easily, the potential over-inclusiveness of the borderline diagnosis with relation to other DSM-III conditions remains an area of considerable concern (Perry & Lerkman, 1978; Lerner, Sugarman, & Gaughran, 1981).

Efforts to differentiate MPD and BPD have been complicated by the ongoing consideration of the two syndromes at different levels of theoretical conceptualization. Phenomenologically, MPD and BPD share many diagnostic features (Putnam et al., 1986; Kluft, 1987a, 1987b; Horevitz & Braun, 1984; Clary et al., 1984). In a study of twenty MPD patients, Ross, Heber, Norton and Anderson (in press) found that twelve (60%) met DSM-III criteria for BPD. Horevitz and Braun (1984), in a review of the phenomenology of thirty-three cases of MPD, found that 70% met DSM-III criteria for BPD while the other 30% did not. The use of the Global Assessment Scale (GAS) further differentiated the groups. A significant difference existed between those individuals with the highest GAS measurement and those with the lowest GAS scores. In addition the GAS score differentiated between MPD patients who met criteria for BPD and those who did not.

Etiologically, both MPD and BPD are considered to be primarily psychodynamically based forms of psychopathology which reflect early developmental life experiences. Several investigators have considered the relationship of MPD psychic organization to borderline personality organization. Clary et al. (1984), in reviewing treatment of eleven patients with MPD, contrasted the defensive styles and personality organizations of these cases to the psychoanalytic understanding of to borderline personality organization. They conclude that MPD represented a "special instance of borderline personality disorder" (p. 98). Kernberg (in press) states that MPD is not to be associated with any one level of personality organization but can be found in neurotic, borderline, and psychotic character structures.

Phenomenologically MPD and BPD show considerable overlap. However, there remains considerable debate as to whether MPD represents a variant of borderline personality organization or whether it represents a distinct defensive organization.

To better define and clarify similarities and/or differences among the three DSM-III-R diagnostic groups of schizophrenia, BPD and MPD, subjects with these respective diagnoses were tested with a broad battery of psychological tests and a series of structured interviews.

METHOD

Subjects: the three groups were selected from inpatient and outpatient psychiatric facilities in the Philadelphia area. Subjects were originally diagnosed by their psychotherapists and referred to the study based on these diagnoses. Subjects' diagnoses were confirmed using the Structured Clinical Interview for DSM-III-R — Patient Version (SCID) (Spitzer, Williams, & Gibbon, 1987). The SCID, however, does not have a module on dissociative disorders; therefore, the diagnosis of MPD was made according to DSM-III-R criteria and confirmed by data collected by another psychiatric interview, the Dissociative Disorder Interview Schedule (DDIS) (Ross, Heber, Norton, & Anderson, 1988). The diagnosis of BPD was confirmed based on data collected throughout the interviews and based on the patients, endorsement of five of eight DSM-III-R (American Psychiatric Association, 1987) criteria for BPD. The DDIS does ask specifically about each of the eight symptoms from which the diagnosis of BPD is made. Subjects were then sorted into three groups based on whether they met criteria for MPD, for schizophrenia (SCHIZ), and for BPD. The MPD group consisted of sixteen subjects and the BPD and SCHIZ groups consisted of eleven subjects each.

Procedure: The purpose of the study ("We are interested in better understanding factors, particularly relating to past events and current symptoms, important in assessing various psychiatric diagnoses.") was explained to each subject, and informed consent to participate was obtained. The SCID and DDIS were then administered by one of two trained clinicians. When these were completed the subjects were given three additional questionnaires to fill out: (1) the Minnesota Multiphasic Personality Inventory (MMPI); (2) the Millon Clinical Multiaxial Inventory (MCMI); and (3) the Dissociative Experiences Survey (DES).

Materials: The following is a brief description of each of the instruments utilized in the study.

The SCID (Spitzer et al., 1987) is a structured interview that guides the clinician through a systematic and thorough assessment of symptoms needed to meet criteria for the following current and past Axis I disorders: Mood Disorders, Psychotic Disorders, Substance Use Disorders, Anxiety Disorders, Somatoform Disorders, Eating Disorders, and Adjustment Disorders.

The DDIS (Ross et al., 1988) is a psychiatric interview that questions subjects about specific experiences that meet criteria for dissociative disorders as well as symptoms frequently associated with dissociative disorders. The MPD criteria employed by the DDIS are the NIMH Research Criteria which include the DSM-III criteria plus two additional criteria. The two are: (1) that two or more personalities have been in control of the subject's body on three or more occasions; and (2) a form of amnesia exists among the different personalities. This instrument also assesses borderline personality disorder criteria as defined by DSM-III-R. In addition, there are sections assessing somatic, depressive, Schneiderian first rank psychotic and substance abuse symptoms. There are also questions about previous psychiatric treatment, as well as any history of physical or sexual abuse.

The DES (Bernstein & Putnam, 1986) is a questionnaire that asks respondents to mark the percentage of time that each of twenty-eight dissociative-like experiences happens to them.

The MMPI (Hathaway & McKinley, 1983) and MCMI (Millon, 1982) are self-report personality inventories. They present the subjects with 566 and 175 true/false questions, respectively. They are then scored for several scales. Reliability measures for the MMPI scales in psychiatric populations (Hathaway & McKinley, 1983) vary between .36 and .93. Millon (1982) reports reliability coefficients of between .61 and .91 for the MCMI scales.

Analyses of various (ANOVAs) were conducted on scores generated by each of these measures for the main effect of subject group. When there is a significant main effect for subject group on any of the scores, pairwise post hoc comparisons were conducted. The Tukey honestly significant difference (HSD) method was selected because, according to Hays (1981) ". . . it is simple, widely used, and flexible in application" (p. 434).

RESULTS

The data were analyzed with respect to whether the diagnostic interviews and/or the personality inventories were able to distinguish the MPD subjects from the other two groups of psychiatric subjects. Table 1 summarizes the information generated by the SCID. The MPD and BPD groups showed similar diagnostic data according to the SCID, with a predominance of patients being diagnosed with mood disorders. The major difference between the MPD and BPD groups was the greater incidence of anxiety disorders in the MPD group. The SCHIZ groups predominantly met criteria for schizophrenia and rarely had other diagnoses.

Differences among the groups with respect to the lifetime prevalence of a major depressive episode according to the SCID were also evaluated with a significant main effect for group ($F(2,35) = 10.40$, $p < .01$). Post hoc Tukey tests revealed that the MPD and BPD groups did not differ from each other with respect to their meeting lifetime criteria for a Major Depression, but both had a significantly higher percentage than the SCHIZ group (MPD: $F(1,35) = 14.48$, $p < .01$; BPD : $F(1,35) = 18.69$, $p < .01$).

Table 2 presents a summary of the information generated by the two measures specifically designed to distinguish between MPD patients and other psychiatric patients.

The DDIS clearly confirmed the presence of MPD in the MPD group and ruled it out in the other two subject groups. However, the interview also highlighted other differences among the groups. A series of ANOVAs was completed looking at types of symptoms among the three subject groups.

There was an overall group effect for the presence of somatic symptoms ($F(2,35) = 12.05$, $p < .01$). Post hoc analyses revealed that both the BPD ($F(1,35) = 9.04$, $p < .01$) and SCHIZ ($F(1,35) = 22.75$, $p < .01$) groups reported significantly fewer symptoms than did the MPD group.

There was also a significant overall effect for the presence of Schneiderian first rank symptoms (FRS) ($F(2,35) = 10.29$, $p < .01$). The BPD group reported fewer FRS than either the MPD ($F(1,35) = 13.88$, $p < .01$) and the SCHIZ groups ($F(1,35) = 17.63$, $p < .01$). The MPD and SCHIZ groups did not differ significantly from each other ($F(1,35) = .72$, $p < .41$) on the mean number of FRS reported.

The groups did not differ at all with respect to history of substance abuse ($F(2,35) = 1.2$, $p < .31$).

Thus, a combination of these two semi-structured diagnostic interviews helped to differentiate these three groups. The SCID was able to isolate schizophrenic subjects from

TABLE 1
Frequency of SCID Derived DSM-III-R Diagnosis for the Three Subject Groups

Diagnosis	MPD (n = 16)	BPD (n = 11)	SCHIZ (n = 11)
Mood Disorder	12	10	1
Schizophrenia	2	0	11
Substance Abuse	0	3	1
Anxiety Disorder	12	3	1
Somatoform Disorder	0	0	0
Eating Disorder	2	1	1
Number of Diagnostic Criteria met Lifetime	3.5	3.3	1.5

TABLE 2
Summary of DDIS and DES Information

	MPD	BPD	SCHIZ	RESULT
Percent MPD Criteria	100	0	0	a,b
Percent Major Dep. Criteria	75	91	18	b,c
Percent Substance Abuse	47	55	27	
Percent Physically Abused	75	64	18	b,c
Percent Sexually Abused	94	64	9	b,c
# Somatic Symptoms	8.8	3.6	6	a,b
# Schneiderian Symptoms	4.8	1.2	5.6	a,c
DES Score	48.6	23.5	12.6	a,b

a: BPD significantly different from MPD.
b: SCHIZ significantly different from MPD.
c: SCHIZ significantly different from BPD.

TABLE 3
Frequency of Sexual Abuse for MPD and BPD Subjects

Frequency	MPD	BPD
0	1	4
1 - 10	1	5
> 10	14	2

TABLE4
Age of Onset of Sexual Abuse for MPD and BPD Subjects

Age (years)	MPD	BPD
1 - 5	13	1
6- 10	2	3
> 10	0	3

MPD and BPD subjects based on the presence of symptoms of schizophrenia and the absence of other symptoms. The DDIS was then able to distinguish the MPD and BPD groups from each other based on the greater incidence of dissociative disorder symptoms and Schneiderian FRS in the MPD group.

The DDIS assesses history of sexual abuse which is considered to be an important etiological factor in the development of dissociative phenomena. A high incidence of sexual abuse was reported by both the MPD and BPD group. However, as Tables 3 and 4 illustrate, the severity of abuse as measured by the overall frequency of abuse and the age of abuse onset is much greater in the MPD group.

The differences in mean DES scores (see Table 2 for comparative means) for the three groups was significant ($F(2,35) = 19.20$, $p < .01$). Post hoc Tukey tests showed the MPD group to have significantly higher DES scores than the BPD ($F(1,35) = 16.96$, $p < .01$) and the SCHIZ group ($F(1,35) = 34.90$, $p < .01$. Therefore, combining the information obtained from the DES and the DDIS allows for further differentiation of the MPD from the BPD group.

Tables 5 and 6 present the means of the MMPI and MCMI-II scales for each of the three groups. A multiple regression analysis for each of these two personality inventories was performed with the subscales as dependent measures and subject group as the independent variable. In addition, post hoc (Tukey tests) comparisons between each pair of groups was performed as well. The significant differences for each scale between the pairs of groups are also summarized in those two tables. The following discussion of results will focus on the most interesting comparisons.

The most striking finding for both the MMPI and MCMI was how clearly differentiated the SCHIZ group was from each of the other two groups on many of the scales, but how few of the scales differentiated the MPD and BPD groups from each other.

The comparison between the MPD and BPD groups on the personality measures is of most interest. The only scale that was significantly different between the MPD and BPD groups on the MMPI was the HS scale ($F(1,35) = 4.77$, $p < .05$), with the MPD group yielding higher scores.

The MCMI was even more striking in its lack of differentiation between the MPD and BPD groups. Of the 25 scales measured only the B (alcoholism) scale showed a significant difference ($F(1,35) = 4.65$, $p < .05$). However, as can be seen in Table 6, the MCMI clearly differentiated the SCHIZ group from each of the other two groups in that their scores on twelve subscales for the BPD group and seven subscales for the MPD group were significantly different.

DISCUSSION

In the current study we have looked at a number of clinical validators in order to define areas of difference and of similarity among schizophrenia, borderline personality disorder, and multiple personality disorder. While MPD has frequently been subsumed within the other two diagnostic categories, our results define a number of clinical features which differentiate MPD from both schizophrenia and BPD.

In keeping with the major etiologic model of MPD (Kluft, 1987a), we found that early and severe childhood trauma was a hallmark of our MPD population. Seventy-five

percent of the MPD patients reported physical abuse, and 94% reported sexual abuse. In contrast, in the BPD group, 64% reported physical abuse and 64% reported sexual abuse. Of the schizophrenics, 18% reported physical abuse and 9% reported sexual abuse. While both the MPD and BPD groups reported high rates of child abuse, the severity of abuse was markedly greater for the MPD patients. In comparing the characteristics of the sexual abuse reported by the BPD and MPD patients, the MPD group reported a greater number of assailants, an earlier age of onset, a later age of cessation of abuse, and a greater number of kinds of childhood sexual experience.

Our results also support an association between extreme childhood abuse and dissociative experiences. We found a high correlation between the DES scores and all severity of abuse measures. The MPD group had a mean DES score twice as high as the mean score for the BPD group. This finding is consistent with the work of Herman, Perry, and van der Kolk (1989), who found a correlation between DES scores and severity of abuse in a controlled study of a group of borderline subjects. They propose a model for conceptualizing child abuse survivor syndromes with a range of adaptation to various degrees of childhood trauma. In this scheme, dissociative disorders represent an extreme form of adaptation, borderline personality an immediate form, and certain somatization and anxiety disorders a less extreme form of adaptation to abuse. In this light, it is noteworthy that our three groups also differed with regard to report of somatic and anxiety symptoms. While few of the patients in our study met DSM-III criteria for somatization disorder, the mean number of somatic complaints were 9, 4, and .6, respectively, for the MPD, BPD, and schizophrenic groups. In addition, 75% of the MPD patients met DSM-III-R criteria for a current anxiety disorder in contrast to 27% of the borderline patients and 9% of the schizophrenics.

TABLE 5
Mean MMPI Scale Scores for the Three Subject Groups

Scale	MPD	BPD	SCHIZ	RESULT
L	47.4	46.5	46.8	
F	89.8	84.5	70.2	b,c
K	49.5	44.8	51.4	c
HS	75.9	67.0	59.6	a,b
D	86.3	92.8	75.5	b,c
HY	74.2	72.7	66.	c
PD	85.0	87.4	78.1	
MF	49.0	50.1	54.1	
PA	82.1	81.3	67.9	b,c
PT	81.6	85.2	72.1	b,c
SC	104.1	94.5	83.7	b
MA	66.6	58.9	55.2	b
SI	71.4	77.0	63.2	b,c

a: BPD significantly different from MPD.
b: SCHIZ significantly different from MPD.
c: SCHIZ significantly different from BPD .

Our findings support a clear differentiation between schizophrenic and multiple personality patients in terms of psychological profiles on the MMPI and MCMI inventories. MPD was distinguishable from schizophrenia on both the MMPI and the MCMI. The predominant mean MMPI profile for the schizophrenic group was 8/4/2, whereas it was 8/2/4 for the MPD group. The MPD patients showed significantly greater overall elevations than did the schizophrenics on all scales except 5, the Masculinity/Feminity scale. It is noteworthy that the MPD patients had markedly higher scores than the schizophrenic patients on the F and Sc scales, which are considered to be the most specific for schizophrenia. The MCMI also differentiated the MPD group from the schizophrenic group, with the MPD patients showing a much more acute and polysymptomatic picture than that shown by the schizophrenic patients.

Schneiderian first rank symptoms were found to be extremely common in MPD patients. While only two of the MPD patients met DSM-III-R criteria for schizophrenia, 94% reported at least one Schneiderian first rank symptom, with a mean of 4.8 FRSs per patient. This compared with a mean of 5.6 FRSs in the schizophrenic group. Ross et al. (1989) found a higher rate of FRSs in their MPD group than in their schizophrenics, with a mean of 6.6 per patient. A differential item analysis of the Schneiderian signs in this study reveals a high rate of auditory hallucinations and passive influence experiences in the MPD group, with relatively little interference with thought process, i.e., thought withdrawal or broadcasting. In light of the pronounced differences between the MPD and schizophrenia groups on all other measures, including the MMPI, MCMI, DES, and abuse history, the specificity of Schneiderian signs for schizophrenia must be abandoned. Schneiderian signs are non-specific; in fact, they should raise suspicion of MPD or another dissociative disorder rather than a thought disorder.

In contrast to the clear differentiation of MPD from schizophrenia across psychological test measures, the MPD and BPD groups showed many areas of similarity. However, MPD patients were clearly differentiated from BPD patients by differences in antecedent history, specifically the severity and extent of childhood physical and sexual abuse, and the degree of dissociative symptoms.

Indeed, many areas of overlap were found in the phenomenology of MPD and BPD patients. Both patient groups were polysymptomatic and met DSM-III-R criteria for an average of at least two other concurrent major psychiatric

TABLE 6
Mean MMPI Scale Scores for the Three Subject Groups

Scale	MPD	BPD	SCHIZ	RESULT
Disclosure	77.9	81.9	64.3	c
Desirability	42.5	36.5	55.5	c
Debasement	85.6	90.8	57.7	b,c
Schizoid	81.0	79.9	66.4	
Avoidant	102.9	103.5	81.3	b,c
Dependent	71.6	74.9	66.4	
Histrionic	46.3	49.1	54.1	
Narcissistic	40.1	45.0	58.7	
Antisocial	65.1	72.8	64.4	
Aggressive/Sadistic	57.5	68.0	58.4	
Compulsive	50.6	51.2	60.3	
Passive-aggressive	87.4	99.5	68.4	c
Self-defeating	97.3	104.5	70.5	b,c
Schizotypal	81.3	79.5	70.2	
Borderline	91.9	98.1	66.4	b,c
Paranoid	59.8	62.7	63.5	
Anxiety	71.4	85.0	50.6	b,c
Somatoform	56.8	60.8	52.8	
Bipolar: Manic	50.7	44.6	39.0	
Dysthymic	81.7	91.4	54.7	b,c
Alcohol Dependence	59.4	74.8	46.4	a
Drug Dependence	63.0	73.4	49.1	c
Thought Disorder	74.0	74.5	61.6	c
Major Depression	76.4	86.6	47.8	b,c
Delusional Disorder	59.4	56.5	55.1	

disorders. Importantly, the groups differed on the extent to which they endorsed DSM-III-R criteria for borderline personality disorder. All of the patients in the BPD group met at least five of eight DSM-III-R BPD diagnostic criteria for inclusion in the study, with an average of 6.6 per patient. In contrast, only two of the MPD patients met DSM-III-R criteria for borderline personality disorder with a mean of 3.7 BPD criteria for the MPD group as a whole.

Both MMPI and MCMI profiles for the MPD and BPD groups were remarkably similar. In both cases, the profiles were consistent with the most commonly reported mean borderline personality disorder profiles for these instruments (Patrick, 1984; Evans, Ruff, Braff, & Cos, 1986). A number of investigators who have studied MPD patients with the MMPI have obtained the same results. In general, they were characterized by extremely elevated F and Sc scales, an 8/2/4 profile, technically invalid inventories due to too many extreme subscale elevations, and a polysymptomatic picture (Brandsma &Ludwig, 1974; Wilbur, Brandfeldt, & Jameson, 1972; Larmore, Ludwig, & Cain, 1977; Solomon & Solomon, 1982; Solomon, 1983; Coons & Sterne, 1986; Bliss, 1984; Kemp, Gilbertson, & Torem, 1988). Two available studies have compared MPD and BPD patients using the MMPI. Kemp et al. (1989) found no significant differences among mean scales to differentiate the groups. Coons and Fine (1990) report a 68% accuracy rate for the differentiation of MPD MMPI profiles from profiles from a large sample of patients with a range of diagnoses including BPD and schizophrenia, but fail to report which specific factors supported their distinguishing the groups.

The discrepancy between the historical/descriptive and psychometric findings for the MPD and BPD groups raises a number of important questions. The first is whether MPD represents a subset or variant of BPD (Bliss, 1980; Horevitz & Braun, 1984; Clary, et al., 1984). While there were "borderline" tendencies in our MPD group, few MPD patients would have been diagnosed with the disorder. Many nosologists have debated the current over-inclusiveness of the borderline personality disorder diagnosis (Perry & Klerman, 1978; Gunderson & Kolb, 1978; Spitzer, Endicott, & Gibbon, 1979; Liebowitz, 1979; Lerner, Sugarman, & Gaughran, 1981; Kroll, Martin, Lori, Pyle, & Zunder, 1981; Andrulonis, Glueck & Stroebel, 1982; Frances & Clarkin, 1983; Akiskal & Chen, 1985).

With regard to the MMPI and MCMI profiles of the MPD group, the specificity of the personality inventories themselves must be addressed. The MMPI was designed before MPD was characterized and well defined as a clinical entity. Subsequently, no systematic consideration of dissociative symptoms within one subscale exists. Instead, a host of symptoms common to MPD are found dispersed across several scales. No consolidation of these indicators has yet been categorized which might increase the specificity of the instrument.

Additionally, the heterogeneity of mean MMPI and MCMI profiles has been described (Antoni, Tischer, Levine, Green, & Millon, 1985a; 1985b). Millon has noted that a look at combined MMPI and MCMI high point profiles of the 2/8 MMPI profile resulted in three stable and distinct clusters. He

suggests that mean MMPI scale scores alone lack specificity and at times represent several distinct clinical pictures. In this study such a combined high point analysis was not possible due to the limited sample size, but it should be considered for future investigation. This possible lack of specificity of mean MMPI profile findings for distinguishing MPD from BPD is further supported by the similar MMPI and MCMI profiles of Vietnam Veterans with PTSD (Fairbank, Keane, & Malloy, 1983; Keane, Malloy, & Fairbank, 1984).

It may be that the psychometric profile on MMPI and MCMI identified in PTSD, BPD, and MPD represents a common final pathway for three groups of patients which share overarching features: an extremely high degree of internal disorganization, a high level of affective instability, and extreme distress. All three disorders are highlighted by marked affective states and a failure to fully integrate certain experiences. They are all partially defined by either splitting of the ego, alternate personality formation, and/or flashback phenomena. Co-morbidity of these disorders aside, the similarity in psychological profile calls into question the instruments' reliability in differentiating severe character pathology from post-traumatic disturbances.

The profile of these measures that is defined as the characteristic profile for BPD may often actually represent a case of MPD and should raise clinical suspicions of a dissociative disorder. Diagnosis can best be made and confirmed, then, by evaluating the extent of dissociative symptoms, and reviewing the patient's history for evidence of severe child abuse. ■

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