MULTIPLE PERSONALITY DISORDER: PHENOMENOLOGY OF SELECTED VARIABLES IN COMPARISON TO MAJOR DEPRESSION

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ABSTRACT

Various findings from a retrospective survey of 355 multiple personality disorder (MPD) patients and 235 major depression patients, who served as a comparison group, are discussed. The survey was completed by 448 independent clinicians, 142 of whom contributed information on both an MPD and a major depression patient. The study confirms recent findings in the literature that MPD is not a rare disorder, its sufferers include a preponderance of females, and it is highly correlated with childhood trauma, especially sexual and physical abuse. In addition, the study indicates that clinicians who diagnose MPD perceive clinical phenomena in a manner similar to those clinicians who have not yet made this diagnosis.

INTRODUCTION

Recent years have witnessed an upsurge of clinical and theoretical contributions to the study of multiple personality disorder (MPD), a venerable but still controversial chronic dissociative psychopathology. These explorations indicate that multiple personality disorder is a posttraumatic syndrome (Kluft, 1987; Putnam, 1985; Schultz, Braun, & Kluft, 1987; Spiegel, 1984, 1986) of childhood origin (American Psychiatric Association, 1987; Kluft, 1984a; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton & Wozney, 1989), that is far from rare (Allison, 1974; Bliss, 1980; Braun, 1984a; Coons, 1984; Greaves, 1980; Kluft, 1984a; Putnam et al., 1986; Ross et al., 1989), and that it appears to be highly correlated with severe abuse and neglect in childhood (American Psychiatric Association, 1987; Bliss, 1980, 1984; Braun & Sachs, 1985; Coons & Milstein, 1986; Greaves, 1980; Ross et al., 1989; Wilbur, 1984). Pioneering studies by Bliss (1980, 1984), Coons and Milstein (1986), Putnam et al. (1986), who reported on 100 MPD patients described by 92 independent clinicians, and Ross et al. (1989), whose series included 236 MPD cases reported by 203 clinicians (1989), have broadened our understanding of this condition's phenomenology. Kluft (1985a), surveying the patient careers of over 200 individuals with MPD, has explored how previously unappreciated aspects of this condition's natural history often complicate its diagnosis and underrepresent its true prevalence.

PURPOSE

The current study was undertaken to explore various phenomena associated with this disorder and to gain further insights into the epidemiology and etiology of MPD. In addition, this study is the first of the authors' ongoing series of investigations comparing and contrasting the phenomenology of MPD to several other mental disorders. Finally, a review of the literature reveals no published study that includes and compares a large cohort of MPD patients to those with another disorder.

Major depression patients were selected as a comparison population in the current study because major depression is a common disorder (Craighead, Kennedy, & Raczynski, 1984; Weissman & Boyd, 1985) that may begin at any age (American Psychiatric Association, 1987) and appears to show no proclivity for any social class (Weissman & Boyd, 1985). In addition, major depression is diagnosed more frequently in women than in men (American Psychiatric Association, 1987; Weissman & Boyd, 1985, Weissman & Klerman, 1977) paralleling current findings that victims suffering MPD are primarily female (Coons & Milstein, 1986; Putnam et al., 1986; Ross et al., 1989) and generally not diagnosed until the late 20's or 30's (Allison, 1974; Bliss, 1980; Coons & Milstein, 1986; Kluft, 1985a; Putnam et al., 1986). Finally, the predisposition to depression, as described by Bibring (1957), may be similar to that of MPD. Bibring suggested that a loss of self-esteem in childhood was characteristic for those who develop depression.

METHOD

Extensive field testing in May, 1985 demonstrated that few clinicians (under 3%) would fill out a long survey instrument. The authors elected to pursue a limited number of inquiries in a more readily accepted format.

TABLE 1
Demographic and Social Characteristics

Questionnaire Item	MPD (N=355) %	Major Depression (N-235) %	Significance
Gender			p<.001
Female	90	73	
Male	10	27	
*Age Categories			p<.001
<10	0.3	0.4	
11 - 20	5	4	
21 - 30	27	12	
31 - 40	48	41	
41 - 50	16	22	
51 - 60	3	10	
>60	0.3	10	
Race			N.S.
Black	6	3	
Caucasian	89	84	
Hispanic	4	1	
Other	2	2	
Religious affiliation			p=.002
Catholic	22	26	
Jewish	5	11	
Protestant	48	47	
None	21	13	
Other	5	3	
Marital status (present)			p+.03
Never married	34	26	
Living with significant other	6	3	
Married	33	43	
Separated	4	5	
Divorced	20	19	
Widowed	2	4	
Socioeconomic status			p<.0001
No income	21	11	
<$10,000	24	20	
$10,001 - $20,000	24	20	
$20,001 - $30,000	15	21	
$30,001 - $40,000	6	9	
$40,001 - $50,000	2	7	
>$50,000	5	13	
Receiving federal or state aid	32	16	p<.0001
Education			N.S.
<High school graduate	11	7	
High school graduate	45	36	
Some college	13	13	
College/professional degree	31	44	

*Mean age: MPD, 34 years; major depression, 43 years

The authors designed a two-page questionnaire to study aspects of MPD including: prevalence; demographic and social characteristics; history of abuse and neglect; intellectual potential; clinical symptoms; the imaginary companion phenomenon; and creativity. Some of the findings will be described at this time; others will be the subject of further communications.

The second questionnaire was sent to 676 clinicians who had indicated an interest in MPD. Their names were compiled from the mailing list of the International Society for the Study of Multiple Personality & Dissociation, an international directory of clinicians interested in the treatment of MPD, and various registration lists from workshops and courses about MPD. Each was sent a questionnaire requesting retrospective information on one MPD patient.

For the purpose of this study, each clinician was asked to select and describe the patient who has/had fulfilled the DSM III criteria (American Psychiatric Association, 1980) for the diagnosis of MPD and had been in therapy with him/her for the longest period of time of all MPD patients in his/her caseload. A copy of the DSM III criteria was enclosed with each questionnaire.

The same questionnaire was adapted for major depression, and was sent to 1106 clinicians. Their names were compiled from the following sources: various registration lists of workshops and courses unrelated to MPD; all members of two local professional groups; those who had indicated an interest in MPD but had returned their MPD questionnaire stating that despite their interest they had had no experience with this disorder; and those who had completed the MPD questionnaire and indicated a willingness to participate in further research.

The study and comparison questionnaires were mailed between July and September of 1985. The overall return rate was approximately 50% for the MPD mailing and approximately 10% for the comparison group. However, a considerably higher returnage (60%) of major depression questionnaires was received from clinicians who had also completed the MPD questionnaire.

Data were analyzed on a Honeywell DPS-8 computer utilizing the Statistical Package for the Social Sciences (SPSS). Categorical data were analyzed within contingency tables by Chi-square or Fisher's Exact Test and continuous data by the t-test procedure.

RESULTS

Characteristics of Clinicians. The 590 patients (355 MPD/235 major depression) included in this study were contributed by 448 clinicians. Two hundred and thirteen of these clinicians supplied information on one MPD patient they had treated; 93 clinicians contributed information on one major depression patient; and 142 clinicians provided information on both an MPD and major depression patient.

There was no significant difference in the distribution of disciplines between the clinicians contributing a patient to either the subject or comparison group. In addition, the clinicians contributing a patient to both the study and comparison group did not differ in their composition according to disciplines to those who contributed a patient to only one group. The composition of respondents' disciplines included approximately 30% psychiatrists, 45% Ph.D. psychologists, and 25% who were either therapists holding masters degrees or nurse clinicians. Both major depression and MPD patients had been in treatment with their reporting clinicians for an average of 3 1/2 years.

TABLE 2
Responses to Inquiries Regarding Abuse

Questionnaire Item	MPD (N=355) %		Major Depression (N-235) %		Significance
Abuse					
Incidence	98		54		p<.0001
Type(s)					
Physical	82		24		p<.0001
Sexual	86		25		p<.0001
Psychological	86		42		p<.0001
Neglect	54		21		p<.0001
All of above	47		6		p<.0001
Physical and sexual	74		14		p<.0001
	Mean	S.D.	Mean	S.D.	
Beginning age of abuse	3.3	2.6	7.5	8.7	p<.0001
Ending age of abuse	17.3	7.5	22.6	15.6	p<.001
Age at single episode of abuse (for those reporting only one episode)	13.8	24.3	15.5	20.3	N.S.

In response to inquiries on the major depression questionnaire there were no statistically significant differences (with the exception of the reporting of a higher incidence of physical abuse) between the clinicians (n=142) who had also completed the MPD questionnaire and those clinicians (n=93) who, to the authors' knowledge, had no experience with MPD. This included their reporting of depressive symptoms and their reporting on the variables on Tables 1 and 2 (with the exception of higher reporting of physical abuse, p=.01, reported by the group of clinicians who also treat MPD patients).

The 355 clinicians completing the MPD questionnaire reported having treated 2513 MPD patients in their practices. The median number of MPD patients per clinician was 2.5, with a range of one MPD patient (reported by 80 clinicians) to over 100 MPD patients (reported by 2 clinicians).

Alternate Personalities. The subject group had a mean of 17 alternate personalities per patient (mean±SD=17±20.6). Fifty percent were reported to have 10 or less alternate personalities and 50% were reported to have more than 10.

Demographic and Social Characteristics. On Table 1, with the exception of race and education, all findings are statistically significant. Highlights include: MPD female to male ratio of 9:1/comparison group 4:1; more MPD patients never being married and having incomes under $10,000 or no income, and receiving Federal or State aid. In addition, the study group has significantly fewer Jews, fewer are currently married or have every been married, and less have incomes over $50,000 or a college or professional degree. Postgraduate and professional degrees had been attained by 15% of the MPD patients and 22% of the major depression group. These degrees included master degrees (diverse), masters in social work, and various nursing degrees (13% of MPD group/16% of major depression group). Doctoral degrees (Ph.D. or equivalent) were held by 2% of the MPD group and 4% of those with major depression. Two percent of the major depression group had degrees as medical doctors; no physicians were encountered in the MPD group.

History of Abuse and Neglect. All differences on Table 2 are statistically significant with the following exceptions: similarities in the mean age (approximately age 14) of reported single episodes of abuse; and duration of abuse (14 years) in both the study and comparison group. Highlights include the following statistically significant findings: incidence of reported abuse (MPD 98%/major depression 54%); physical abuse (MPD 82%/major depression 24%); sexual abuse (MPD 86%/major depression 25%); and reported physical and sexual abuse in the same patient (MPD 74%/major depression 14%).

DISCUSSION

Prevalence. In as much as the study group includes 355 MPD patients all meeting DSM III criteria and each reported by a separate independent clinician, and these 355 reporting clinicians have treated a total of more than 2500 MPD patients, this study offers further confirmation that multiple personality is not a rare condition. It is consistent with Putnam et al.'s study (1986) in which 92 independent clinicians reported 100 MPD patients, Kluft's article (1986a) listing 10 individuals or groups each reporting 10 to over 200 cases in their clinical or research work, and the work of Ross, et al. (1989), whose series included 236 MPD cases reported by 203 clinicians, who had seen a total of 1807 MPD patients.

However, in spite of such reports and empirical studies, the myth of rarity (American Psychiatric Association, 1987; Kline, 1984; Orne, Dinges, & Orne, 1984; Thigpen & Cleckley, 1984) persists, contributing to both the underdiagnosis and misdiagnosis (Kluft, 1986b). Difficulty in diagnosis (Bliss, 1980; Braun, 1986; Coons, 1984; Kluft, 1984b, 1985b, 1987; Putnam, Loewenstein, Silberman, & Post, 1984; Putnam et al., 1986; Solomon & Solomon, 1982) and resulting problems with estimating prevalence and incidence of MPD (Kluft, 1986a, 1986b; Putnam, 1989) is also exacerbated by: 1) the incredulity in response to retrospective reports of abuse (Goodwin, 1985); 2) the variability of presentation, both between patients as individuals, and in the same patient over time (Kluft, 1985a) in a condition widely assumed to be fairly stereotypic and fixed in presentation; and 3) attempts on the part of MPD patients to disguise rather than flaunt their condition (Kluft, 1985a).

Characteristics of Clinicians. There were no significant differences in the current study in the reports of clinicians working with MPD patients and those who have not worked with MPD patients in their responses on the major depression questionnaire (with the exception of reporting physical abuse). Of particular note are the similar responses for the depressive symptoms of their patients. This suggests that clinicians who work with MPD patients do not differ from other clinicians in their perception of clinical phenomenology, although they may be more sensitized to issues of abuse. These findings speak to the credibility of the diagnostic skills of clinicians who treat MPD patients.

Alternate Personalities. In recent decades, the number of reported alternate personalities has continued to increase as therapists are becoming more sophisticated in their awareness of the clinical features of multiple personality (Putnam, 1989). This trend is reflected in the current study for the subject group has a mean of 17 alternate personalities per patient. The median number was 10. These findings are similar to those of Ross, et al. (1989) but somewhat higher than the mean of 13.9 reported by Putnam et al. (1986). In any case, it appears that because this defense mechanism (the creation of alternate personalities) is effective, it is repeatedly used.

Gender. The present study supports reports of the predominance of women among identified MPD patients (Coons & Milstein, 1986; Greaves, 1980; Kluft, 1984b; Putnam et al., 1986; Ross et al., 1989) and major depression patients (American Psychiatric Association, 1987; Weissman & Boyd, 1985; Weissman & Klerman, 1977) and duplicates the 9:1

female to male ratio reported by both Putnam et al. (1986) and Ross, et al. (1989). However, a gender bias may exist in the populations that were surveyed. Studies have shown that, regardless of diagnosis, a larger percentage of afflicted females than males enter therapy (Notman, 1989; Weissman & Boyd, 1985) and report symptoms more readily (Notman, 1989). In addition, female patients are more likely to enter the mental health system because of their tendency to direct aggression against their selves (Bliss, 1980; Boor, 1982; Greaves, 1980; Notman, 1989; Putnam et al., 1984). Consequently, the preponderance of males in the correctional system because of their outer-directed aggression (Boor, 1982; Putnam, 1985, 1989; Weissman & Boyd, 1985) and the generally held clinical opinion that fewer sexually abused boys than girls come to public attention (Finkelhor, 1984) may contribute to underreporting of males in both the study and comparison group.

Age. The MPD mean age (34, rage 4 to 62) closely matches the range found in Putnam et al.'s (1986) study (mean age 36, range 11 to 58) and is consistent with findings in smaller studies (Allison, 1974; Bliss, 1980; Coons & Stern, 1986; Horevitz & Braun, 1984; Kluft, 1984a; Solomon & Solomon, 1982) that this syndrome does not generally receive accurate diagnosis until the late 20's or 30's. In addition, the comparison group's mean age (43, range 9 to 80) supports findings that major depression is diagnosed in adulthood (Weissman & Boyd, 1985). However, the mean age for all patients in this study may be elevated because patient selection was based on a sample that the reporting clinicians had been treating for the longest period of time. However, although both groups were diagnosed in adulthood at mean ages in the third and fourth decade, recent findings indicate that MPD has its origin in childhood (American Psychiatric Association, 1987; Kluft, 1984a, 1984c; Putnam et al., 1986; Ross et al., 1989).

History of Abuse. The study group's reported incidence of childhood abuse supports evidence from recent prospective childhood (Elliott, 1982; Fagan & McMahon, 1984; Kluft, 1982, 1984c; 1985b, 1985c, 1985d, 1985e; 1986c; Kluft, Braun, & Sachs, 1984; Weiss, Sutton, & Utecht, 1985) and adolescent (Bowman, Blix, & Coons, 1985; Fagan & McMahon, 1984; Gruenewald, 1971; Kluft, 1985a; Spiegel & Rosenfeld, 1984) cases and retrospective adult reports (Bliss, 1980; Boor, 1982; Braun, 1984b; Braun & Grey, 1986; Coons & Milstein, 1986; Putnam et al., 1984; Putnam et al., 1986; Ross et al., 1989) in the recent literature indicating that childhood trauma, especially sexual and physical abuse, appears to be a primary etiological factor in the origins of MPD. Almost half of the study group reported abuse in all four categories (physical, sexual, psychological, and neglect) and only 12 cases (all adolescents) reported a single episode of abuse.

It is significant that the study group's report of abuse is congruent with Putnam et al.'s (1986) findings of 97%. In addition, while the types of abuse inquired after in the present study were significantly more common the the history of MPD patients than major depression patients ($p<.0001$), it is notable that the incidence of physical (82%) and sexual (86%) abuse reported by the MPD sample is similar to that reported by Bliss (1984), Coons & Milstein (1986), Putnam et al. (1986), and Ross et al. (1989). Also, the proportion of MPD patients in the present study reporting both physical and sexual abuse (74%) is quite similar to Putnam et al.'s (1986) findings of 67%.

The higher incidence of physical abuse reported in major depression by clinicians who also worked with MPD patients suggests that clinicians working with MPD patients may become more attuned to suspect and inquire after abuse experiences. This sensitivity may also contribute to the discrepancy in the incidence of abuse reported by the study and comparison group. In addition, the MPD patients' ability to dissociate from the traumatic episodes and organize the memory of such episodes into alternate personalities which are able to share their memory banks in the course of the treatment may have increased the incidence of the reporting of abuse by MPD patients. In contrast, the comparison group's utilization of repression may have resulted in underreporting, because such memories remain out of their awareness.

Although the reported physical and sexual abuse was not authenticated in the present study, the validity of such childhood traumata is supported by Coons & Milstein's (1986) series of 20 MPD patients in which 17 cases had corroboration of sexual abuse. However, the authors of the present study recognize that the definition of abuse is quite subjective in nature. As stated by Newberger (1983): "Child abuse and child neglect are catch-all euphemisms for a variety of childhood injuries that are believed to be derived from parental acts of omission or commission" (p. 262). The present study utilized a broad (contact and/or noncontact abuse) definition (Wyatt & Peters, 1986) of sexual abuse that includes both the sexual behaviors that do not involve physical contact between perpetrator and victim and those that do involve sexual contact. This follows Finkelhor's (1986) opinion that the collection of all data in abuse experiences has the advantage that analyses can always be modified to fit more restricted definitions since cases that are not collected initially cannot be recovered later.

Research in Progress. The authors are currently preparing for publication follow-up research comparing MPD to borderline personality disorder and post-traumatic stress disorder that includes an exploration of incest and the witnessing of acts of violence to family members.

The research in progress also includes an exploration of the incidence of various types of affective disorders, including major depression, in MPD cohorts. For the purpose of the current study, however, the authors did not make inquiries about concurrent diagnoses in either their MPD or major depression cohorts. In this they followed the observations of Putnam et al. (1984) who, observing the high incidence of signs of depression, anxiety, and other disorders in MPD populations, chose to consider MPD a superordinate diagnosis within which numerous other findings may be encompassed.

Methodological Limitations. The following are methodological limitations of the present study. First, we had to accept the inevitable limitations and compromises inherent in a retrospective study. Second, it is not known of a certainty that the clinicians who responded to the mailings were representative of the broad spectrum of clinicians working with MPD or major depression patients. Thus, the findings may be selectively highlighting a sample that is not representative of the entire spectrum of the two diagnoses. Third, the respondents have varying levels of clinical experience and the study is without interrater reliability. Fourth, the sample was not randomly acquired. Because it is composed of persons seeking psychotherapy, there may be a qualitative difference between those who seek or do not seek treatment. Consequently, our sample may not be representative thus limiting the generalizability of the findings to the larger population. Fifth, by stipulating the reporting of data on the patients in treatment the longest, we may have studied patients who, although better known to their therapists, may not be representative of their overall experience with these mental disorders.

CONCLUSION

The present study needs duplication in order to establish the reliability of the retrospective assessment of MPD using the authors' instrument for inquiry. The present findings also need to be confirmed in a large prospective study that includes MPD patients who remain in long-term treatment with the reporting clinician. Such research endeavors will further corroborate the authenticity of the disorder, assist in verifying the clinical skills of those treating MPD patients, and add to the understanding of MPD's prevalence and phenomenology. ■

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