Multiple Personality Disorder Misdiagnosed as Mental Retardation: A Case Report

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ABSTRACT

A woman was diagnosed as mentally retarded when she was five years of age and spent the next 35 years so classified. She also was considered schizophrenic. Incongruities in her clinical presentation ultimately led to the suspicion that she suffered multiple personality disorder. It was found that she had retreated into an adaptation consistent with the superficial manifest appearance of mental retardation, and that the intrusion of her dissociative psychopathology was mistaken for schizophrenia. Correctly diagnosed and treated, she has made noteworthy gains. Selected issues relevant to the misdiagnosis of MPD are discussed.

Most individuals who suffer multiple personality disorder (MPD) are described as highly intelligent, perceptive, sensitive, and bright (Wiibur, 1984a, 1984b, 1985). Beahrs (1982) writes that "multiple personalities are generally brilliant, with an insatiable curiosity about themselves and life issues"(p. 119). They are often highly accomplished, unquestionably talented, and possess unusual abilities (Wilbur, 1984a). Braun and Sachs (1985) observe "most multiple personality disorder patients show evidence of having above-average intelligence, although this may not be accompanied by outstanding performances on standard intelligence tests" (p. 44).

Although this point of view dominates the literature, Coons (1987) found that a group of MPD patients assessed primarily in a state hopital setting had a mean I.Q. in the range of average intelligence. It is difficult to compare this sample to the anecdotal experiences and clinical estimates of practitioners who have studied MPD patients in outpatient and private practice settings, and may be basing their comments on a rather different population. Caul (personal communication, November 5, 1987), Kluft (1979, 1985, 1987), and Kluft, Steinberg, and Spitzer (1988) have expressed concern that both the publicity that has surrounded certain MPD patients of unquestioned giftedness and the fascination that often accompanies work with the more intelligent and creative individuals with MPD may have unduly influenced clinicians' general expectations about this mental disorder.

Therefore, it is useful to explore whether an unwarranted overreliance upon one of the more consensually accepted but objectively unproven characteristics of MPD may actually increase the incidence of false negative diagnoses. Is it possible that the expectations consequent to such preconceptions could cause therapists to fail to consider MPD in the differential diagnosis of patients who appear to be quite average or even below average in intelligence?

This report offers evidence that, counterexpectationally, MPD can occur in an individual who appears to suffer mental retardation, and manifests many signs consistent with mental retardation over a prolonged period of time (nearly three decades) and in a wide variety of social contexts. This entrenched presentation of what, in retrospect, must be considered pseudoretardation, confused the management of an unfortunate woman from her childhood well into her adult life. The recent literature of MPD has yet to address the issues raised by such a patient. More recent explorations of the differential diagnosis of MPD (Coons, 1980, 1984; Kluft, 1984, 1985, 1987a, 1987b, 1987c, 1988a; Orne, Dinges, & Orne, 1984; Putnam, Loewenstein, Silberman, & Post, 1984; Solomon & Solomon, 1982) emphasize the difficulties encountered in distinguishing MPD from schizophrenia, borderline personality disorder, seizure disorders, malingering, and other dissociative phenomena. They also indicate the importance of diagnosing concomitant mental and neurologic disorders. Interestingly, the sustained appearance of mental retardation is not considered as either a differential or concomitant diagnosis.

CASE HISTORY

Marge (a pseudonym) was a 35- year old married but childless woman when she was referred to a family service agency for psychotherapy. A visiting nurse (who observed Marge in an ocupational rehabilitation setting for the mentally retarded, in which she was a marginal and rather troublesome employee) wrote:

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"Marge is confused about her sexual identity and she is unable to keep jobs as she masturbates in public and makes homosexual advances to women on the job." Marge was observed to engage in obvious and unconcealed self-stimulating behaviors between 30 and 50 times a day.

Marge was the fourth of five children born into an affluent family. At five years of age she had been diagnosed as mentally retarded and emotionally disturbed. Subsequently she had attended special schools and special education programs. She had met her husband, who himself was mentally retarded, in a high school special education class. Marge had been raped several times during her teen years.

Presentation

When assessed in 1979, Marge was a hirsute and overweight woman who interacted with the interviewer in a frank and open manner. Although her history, the results of prior testing, and her mannerisms and style of dress were consistent with the diagnosis of mental retardation, her humor and insightful manner of putting observations and thoughts together caused the evaluator (G.A.) to question its accuracy. Marge met DSM-III (1980) criteria for borderline personality disorder. She was severely anxious and impulse-ridden, with episodes of gorging that verged upon clinical bulimia, and precipitous bouts of alcohol and prescription drug abuse. These usually occurred when she was alone, or felt abandoned. She could not tolerate solitude. Her public masturbation, her pressured homosexual approaches to female co-workers, and her angry outbursts rendered her incapable of sustaining employment. Her actions and reactions had an unmodulated all-or-none quality. However, the same stimuli that led to explosive outbursts on some occasions led to no reactions at others. Often her angry outbursts were not remembered. Her moods were quite labile. A psychiatric consultant considered her to have a major depression, and placed her on imipramine hydrochloride at adequate doses. Her response to medication was often equivocal and difficult to assess.

Marge had numerous somatic and ostensibly medical complaints. Her hirsutism, hypertension, obesity, and amenorrhea led to an extensive endocrinologic evaluation, with no positive findings other than a slightly elevated blood sugar. A plethora of gastrointestinal complaints received a systematic exploration, without positive findings. The forgotten episodes and severe headaches prompted a neurologic evaluation, including a brain scan and electroencephalogram. No organic disorder was discovered.

Psychological Testing

It is unfortunate that the majority of Marge's records have proven unavailable. Most of her psychological testing data is not accessible. To the best of our knowledge, however, once she had been diagnosed mentally retarded, she was not tested very frequently. The tests that were done appeared to confirm the diagnosis of mental retardation, and mention of this is available in her records, but neither the actual scores nor the test protocols themselves can be located. Early in the course of her therapy she was assessed to document her eligibility for certain benefits. On Form A of the Quick Test, she achieved an I.Q. score of 87, which places her in the low average or dull normal range. On the Wechsler Adult Intelligence Scale (WAIS) she scored 75 on the verbal part, 74 on the performance part, and 73 on the full range. The psychologist reported that this placed the patient in the range of borderline mental retardation, between the third and fourth percentile. Marge was noted to have particular difficulty in interpreting human interactions and doing arithmetic problems. There were no bizarre responses or clear breaks in reality testing. The psychologist reported that Marge showed impulsivity and poor judgement, and demonstrated an unusual amount of inconsistency within a number of subtests. Diagnoses of borderline mental retardation and schizophrenia were made.

The paucity of actual data about this patient's psychological test results impedes further commentary upon the role of this type of information in her assessment and evaluation over the years. Some general thoughts will be offered in the discussion section.

The Process of Psychotherapy: Prior to the Correct Diagnosis

Marge began therapy in the spring of 1979. Her attendance was regular, and her relationship with her therapist (G.A.) became a focus of stability in her otherwise chaotic life. It rapidly became clear that her drinking problems were quite severe and that her marriage was very troubled. After a year of primarily supportive counseling focusing on relationships and difficulties in living, Marge spent six months with her family of origin, now relocated to another part of the country. During her absence, she wrote her therapist two or three times each week. Although it was not appreciated at the time, in retrospect it is clear that these letters contained examples of marked differences in handwriting, and that the content and tone of the letters differed with the different handwritings.

Upon her return to treatment in 1981, therapy centered on issues of self-esteem. exploring the consequences of her behavior, control of her drinking, exploration of available life options, and readying Marge and her husband for marital counseling. Marge was able to become abstinent, and her general functioning improved. As she was helped to become more assertive, she handled her anger and frustration more appropriately and she became less impulsive. Her memory gaps, which she called blackouts, were less frequent, but all physical symptoms persisted. Her therapist considered Marge's improving ego functions and level of interpersonal interaction to be inconsistent with mental retardation, and raised the possibility (although there was as yet no firm evidence) that Marge had multiple personal-

ity disorder (MPD), appearing retarded in the personalities that had been most active during the majority of her life. A psychiatric consultant was not familiar with MPD, but doubted the likelihood of such a scenario.

By March of 1982 Marge's increasing trust in her therapist allowed her to explore her homosexual behaviors and her feelings about women. As she felt increasingly comfortable in expressing and processing her feelings about her therapist, she was able to open up about her childhood and her family situation. She volunteered that she had experienced physical and sexual abuse at her mother's hands. Therapy began to focus on the mother-daughter incest. After Marge appreciated that she could discuss these issues openly with the therapist, she was able to reveal similar abuses from her father and older brother. As traumatic events were revealed and relived in the therapy, direct correlations were found between her previously inexplicable physical symptoms and the specific traumata under discussion. Marge now revealed that much of her drinking had been done to block out the emergence of traumatic memories. Although the therapy was painful, and Marge wanted to "kill the pain" with alcohol, she elected not to do so.

At times the gastrointestinal symptoms and the physical pains associated with the traumatic memories were intense. She was hospitalized twice on medical services for its evaluation and management. As she worked with the painful events of her past she often became overwhelmed and suicidal. Five psychiatric hospitalizations were required. On each admission the diagnosis of MPD was suggested, but the patient was considered to have chronic schizophrenia, and placed on substantial doses of antipsychotic medications.

In December of 1983, Marge was referred to a Parents United group for incest survivors. During these meetings Marge switched personalities in a florid and fairly self-evident manner. Although these phenomena disrupted the group, the group's leader recognized them and supported the idea of referral to a consultant experienced with MPD. Fortuitously, the January 1984 issue of PSYCHIATRIC ANNALS, which focused on MPD, came out in the same month that Marge's behavior in group was being discussed by the professionals concerned with her care. Its list of signs suggestive of MPD (Kluft, 1984a was consistent with Marge's behavior. Specifically, she had episodes of amnesia or time distortion, was frequently told of disremembered behaviors, had observable changes in her behavior reported by others, had severe headaches, heard voices within her head telling her to do good and bad things, and had found unfamiliar writing that she could not identify on notes and even on the walls of her home.

At this point, it seemed quite 1ikely that Marge suffered MPD, but those involved in her care were not familiar with the psychopharmacologic and psychotherapeutic management of this condition, and some remained reluctant to endorse this diagnosis. Therefore, she was brought to a clinician experienced with MPD (R.P.K.) for consultation. The consultant confirmed the diagnoses of MPD and major depression, and was able to discover that a layer of "dumb personalities" had been formed to absorb the impact of an overwhelming childhood. He recommended the reduction of the patient's current regimen of major tranquilizers by 10 percent per month and their ultimate elimination, suggested the antidepressants be continued, and recommended that severe anxiety be managed by small doses of anxiolytics. This regimen was successful; on it Marge appeared far more accessible and spontaneous.

The Process of Psychotherapy: Subsequent to the Diagnosis of MPD

Marge proved to have a vey complex dissociative structure, with dozens of well-defined personalities and hundreds of less well-defined entities. She also was continuing to form new dissociative entities to deal with intercurrent stresses. Perhaps the very complexity of her structure impeded its recognition (Kluft, in press). The treatment was carried out in in a manner consistent with the format described in a recent text (Braun, 1986), and will not be detailed in this report. To date, over 150 alters have undergone spontaneous integration in the course of therapy.

The most noteworthy aspect of the treatment itself relates to the dynamics of the particular form taken by this client's dissociative defenses. In brief, Marge had been a very large child, and inappropriate expectations were placed upon her. She was held responsible for housecleaning chores and caring for her grandmother — tasks that she could not accomplish at a level satisfactory to her parents, who insisted on an adult quality of performance. Whenever she failed, she was beaten. After a particularly bad beating, Marge withdrew into herself and closed up. She was taken to a series of doctors and diagnosed as mentally retarded. For the first time, she felt safe. Expectations were reduced, and she was not beaten as frequently. Alters were created to function on a retarded level, but also to preserve normalcy in a clandestine manner. Both types of alters have integrated, and both types persist. Although Marge is much improved, at times she still seeks refuge in the safety of being retarded.

Apart from the more typical difficulties that render work with MPD arduous (Kluft, 1984b), Marge's particular difficulties relate to handling pressures and expectations. As she improves, her husband and his family perceive her as increasingly competent, and expect her to do more and more. In fact she has mastered many significant challenges. For example, she has overcome the residual trauma of having been made a caregiver as a child (and being beaten for her shortcomings) to the point that she can care for her blind diabetic mother-in-law, testing her blood sugar several times daily and preparing her insulin injections. On many occasions she has felt so overwhelmed that she has created new severely retarded alters. This vulnerability

remains a major focus of therapy.

The integrations achieved thus far have been accompanied by remarkable changes in Marge's level of psychological and physical functioning. Prior to the integrations, she had never experienced spontaneous menstruation. Her menses had been regulated with hormones. She was unable to conceive, even with fertility drugs. Currently she has spontaneous, if somewhat irregular, menses; she became pregnant, but suffered a miscarriage. Her appearance has become more feminine. Her gastrointestinal disturbances are much reduced.

Prior to beginning to integrate, Marge found shopping, housekeeping, and making telephone calls overwhelming activities. She could not handle dealing with strangers; she was noted to have a limited behavioral repertoire and was considered to be emotionally empty. She now manages all of the above activities without difficulty, is able to express feeling and emotions to those to whom she feels close, and is increasingly flexible in social situations. Impressionalistically, she seems more alive and her face is far more expressive.

Prior to the first integrations, Marge read very little. As integration proceeded, she became interested in Harlequin romances, and then progressed to more demanding best-selling novels of considerable complexity. She has become curious about the world around her, and takes an active interest in current events. She has begun to draw. Marge continues to make considerable gains in therapy, and her ultimate prognosis appears optimistic.

DISCUSSION

It is unfortunate that most of the records and test scores that relate to Marge's long history within schools, agencies, and treatment settings for the mentally retarded or dually-diagnosed (mental retardation and mental illness) are not available for study, and that clinical considerations dictate against submitting Marge to extensive psychological testing at this point in her treatment. It would be instructive to examine such materials in depth to allow some inferences to be drawn as to how individuals like Marge could be identified and treated at an earlier age.

It is instructive to review intelligence testing quite briefly in order to reflect upon its role in the case under discussion. Because of the limited data avialable regarding Marge, this review must be general, rather than keyed to the imformation in her records.

Intelligence testing originated as a modest attempt by the French Ministry of Education to identify children who did not have the mental ability to benefit from traditional schooling (Landy, 1984). It has become a common tool for the evaluation of fluid and crystallized intelligence (Botwinick, 1977) in both adults and children. Horn and Cattell (1967) state that the fluid function, thought to be based on physiological structure, was best assessed by performance measures, whereas crystallized intelligence, based on learned abilities, is better appreciated in verbal measures. Efforts have been made to reexamine and renorm intelligence testing, factoring out racial, cultural, and socioeconomic determinants (Gilbert, 1969).

The Wechsler Adult Intelligence Scale (WAIS) (Wechsler, 1958) is a measure of acquired knowledge that includes additional items to allow more accurate evaluation at the lower levels of intelligence. The WAIS measures a person's ability at the time of the testing. It does not address issues of the person's potential or biological limits, as would tests that measure intellectual capacity. The WAIS, which replaced the Wechsler-Bellevue, is comprised of 11 subtests, each measuring a mutually intercorrelated ability. Six subtests make up the Verbal Scale, and five the Performance Scale. Scores are reported for both the Verbal and Perfomance Scales as well as a Full Scale I.Q. There can be no disagreement in the scoring of a test, but there may be ample disagreement as to how it is interpreted (Gilbert, 1969).

Mental retardation is diagnosed according to three criteria (American Psychiatric Association, 1987), one of which is an I.Q. of 70 or below in an individually administered I.Q. test. Normal I.Q. functioning on the WAIS is consistent with a score of 100 points +/- 15 points. Scores above 115 are higher than the norm, and scores below 85 are below the norm. Although it is not a formal DSM-III-R category, the term borderline mental retardation is often applied to those with I.Q.s between 70 and 85. The other two DSM-III-R criteria are concurrent deficits or impairments in adaptive functioning, and an onset before age 18.

To make the diagnosis of mental retardation from a standardized test such as the WAIS, psychologists generally consider it essential to see a consistency of scores across the subtests. Therefore, markedly fluctuating scores above and below the subject's mean may be an indication of the disruption of intellectual performance by emotional or physical intrusions rather than a true intellectual deficit, even if the Full Scale score is less than 85 (Gilbert, 1969). Customarily, once such suspicions are raised, further testing (e.g., MMPI and/or Rorschach) is required, and the appreciation of the I.Q. is reframed with their findings taken into account.

Although intelligence testing is not geared to assessing an individual's personality, the converse is sometimes thought to be true. Certain diagnostic categories tend to score in particular intellectual ranges. This well established expectation among psychologists is a not infrequent interfering contaminant of the evaluator's objectivity, and may lead to false negative diagnoses when, for example, a low score is attained by an individual with a condition usually associated with a

higher than average intelligence. Earlier it was noted that MPD patients traditionally have been considered to have high intelligence.

Marge's test results are confusing. Her Full Scale I.Q. is consistent with the diagnosis of borderline mental retardation. However, her Verbal Score, which is marginally higher than her Performance Score, suggests the presence of an emotional conflict rather than a simple diagnosis of mental retardation, in which Performance is often higher than Verbal. Gilbert (1969) notes that the difference need not be significant in order to raise suspicion. The same is implied even more strongly by the observation of "an unusual amount of inconsistency within a number of the subtests." Inconsistent scores on the Digit Span, Object Assembly, and Digit Symbol subtests may be more representative of emotional conflict than of actual mental retardation. Digit Span and Digit Symbol are better measures of anxiety and motivation than of intelligence (Gilbert, 1969). All in all, the co-presence of an inverted Verbal/Performance ratio (admittedly quite marginal and minimal) combined with the noted inconsistency within the subtests suggests a pattern that should have been explored further.

Although the reason these markers did not prompt additonal study will remain obscure, it is possible to speculate about the confusion surrounding the matter of the subscale inconsistency. Remote memory and alertness to the environment are assessed in the Information subtest. If the examiner had noted both the inconsistency on the subtest and the clinician's diagnostic concern, it would have been possible and judicious to administer the Wechsler Memory Scale (WMS) (Wechsler, 1945). That Marge's judgement was deemed poor by the examiner was quite likely reflected by a low score on the Comprehension subtest. Unfortunately, difficulties with this subtest plus ease with the Information subtest are consistent with the diagnosis of schizophrenia. It is known that Marge did poorly on the Arithmetic subtest, which functions as a measure of the subject's ability to concentrate; a low score often reflects organic impairment. This might have been an additional spur to do subsequent testing, perhaps using the WMS (Wechsler, 1945).

All things considered, the examiner's report was rather perfunctory, limited in scope and content, and inconclusive. It was more consistent with the diagnosis of schizophrenia, to which the examiner was not blind. One must wonder if the conclusions reached reflected more an a priori apperception of the diagnoses that were ultimately rendered than an openminded attempt to investigate all possibilities. This situation could have been corrected by communication with the treating clinician, who, indeed, had already questioned the diagnosis of mental retardation and raised the possibility of a dissociative disorder. On the other hand, in support of the examiner's conclusion, there was a long history consistent with the diagnoses that were rendered, and the subject's appearance was consistent with that history. Also, little is known about the psychological test profiles of MPD patients, especially in the area of intelligence testing. In future years, it may be found that "unexplainable" test results and puzzling inconsistencies are a diagnostic marker for the possible presence of a dissociative disorder.

Marge was diagnosed as mentally retarded from age 5 until age 39. Her entire socialization process was based upon this misdiagnosis. She was placed in inappropriate classroom situations that were understimulating, and in which her defensive pseudoretardation and the negative self image associated with it may well have been reinforced. Her cognitive and emotional growth was hampered.

The additional misdiagnosis of schizophrenia further compromised Marge, because it relegated her to types of therapy unlikely to uncover and address her core psychopathology, and led to her being given large doses of antipsychotic medications that sedated her and further blunted her affect and expressivity, reinforcing the impression that she was quite compromised. Furthermore, Marge was among that subgroup of MPD patients (first noted by Cornelia B. Wilbur, personal communication, May, 1978) that experience antipsychotic medications as destabilizing, and dissociate further under their influence. Well over one third of her total number of alters had emerged in connection with her feeling disorganized under the influence of these medications.

The misdiagnosed individual who is considered both mentally retarded and mentally ill is also at risk because of some factors that relate to the sociology of mental health care delivery. Such patients are rarely treated by prestigious individuals or in the private practice setting. They usually are seen in agencies, and their therapists often are without significant administrative contol over their own practices. Often they must subordinate their own judgements to those of their supervisors and consultants. Without challenging the need for such arrangements, they have certain potential liabilities. In this instance, the accuracy of Marge's ostensible diagnosis was questioned as early as 1979, and the possibility of MPD was suggested as early as 1982. In 1983 five psychiatric admissions occurred. On each occasion Marge's therapist suggested she be assessed for MPD. However, these considerations were raised by a professional of relatively low prestige and authority, and had little impact upon Marge's management. The diagnosis of mental retardation was not removed and the diagnosis of MPD was not made and accepted until 1984. Since the treatment of such individuals is likely to remain the province of the master's level therapist, and individuals who remain misdiagnosed may become increasingly socialized to appear to be similar to the others in their environment, it becomes crucial for consultants to attend with care to the concerns of their consultees, and, looking beyond the

for the conditions that they actually suffer.

The case of Marge also demonstrates that the expectation that MPD patients are creative and talented individuals of above normal intelligence is erroneous and begets false negative diagnoses. In fact, an MPD patient's true intelligence can be masked by dissociative psychopathology. Much as Marge's true intelligence was hidden so early in her life that it did not become apparent until she had made significant progress in her therapy and was over forty years of age, the reverse can occur. One author (R.P.K.) recently assessed a young woman with MPD who appeared to have quite marginal intelligence, and learned to his surprise that she had been first in her class until her last year of high school. He learned that at that point her dissociative defenses were mobilized with such vigor that she barely managed to graduate, and had functioned poorly ever since. A further major unsettling event had caused still further regression into "defensive dumbness." Sensitized by his familiarity with Marge's defensive pattern, he was able to deduce the course of this second patient's condition, and remobilize her basic intellectual assets in short order.

Marge entered the mental health/mental retardation care delivery system in approximately 1950, 24 years before the first modern articles on childhood MPD (Fagan and Mc Mahon, 1984; Kluft, 1984c). She presented to the senior author (G.A.) prior to the inclusion of MPD as a free-standing diagnosis in DSM-III (1980), and was under suspicion for MPD during a period in which knowledge about MPD was accumulating rapidly, but was not widely disseminated. Therefore, it is understandable, although regrettable, that so many mental health professionals involved in her care were rather negative or diffident about considering the MPD diagnosis, and discounted the clinical intuition of the primary therapist. Conversely, it is heartening to reflect that the publication of credible professional articles on the clinical presentatation of MPD were able to influence Marge's care in short order, and allow many of those involved in her management to alter their longstanding positions.

As clinicians become increasingly knowledgeable about MPD, its features will be discerned in patients with a wide range of initial presentations, and diagnoses will be made without such lengthy delays. Hopefully, the stereotypic expectations that have already intruded themselves into this new and rapidly expanding field of study can be corrected before they exert major deleterious impacts. Before the advent of DSM-III in 1980, Kluft (1979) reflected that only the most intriguing MPD patients were receiving wide attention, and feared that the unique features of those patients rather than the condition's core psychopathology would become perceived as the essence of MPD. He attempted to warn against characterizing MPD patients as universally conforming with the appearances of the then-publicized cases. Drawing upon a data base of 73 MPD patients, he cautioned against the "SNAALS" and "SALE" syndromes, the discounting of the possible presence of MPD because "she's not at all like Sybil," or because "she ain't like Eve." The case of Marge is a further contribution to this ongoing problem in the diagnosis and differential diagnosis of MPD.

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