

THE CLINICAL
PHENOMENOLOGY
OF MALES
WITH MPD:
A REPORT
OF 21 CASES

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ABSTRACT

We describe 21 male patients meeting DSM-III-R and NIMH criteria for multiple personality disorder (MPD). They were compared with female patients in the NIMH data base on MPD and dissociative disorders. Striking similarities between males and females were found on most variables. Both groups had extensive childhood histories of sexual and physical abuse far exceeding the prevalences reported for other clinical and non-clinical populations. There were trends for males to have more alcoholism and antisocial behavior. Generally, males had more subtle clinical presentations than females and reported fewer alter personalities. Implications of these findings and the limitations of the present study are discussed.

INTRODUCTION

We report data on 21 males meeting DSM-III-R and NIMH research criteria for Multiple Personality Disorder (MPD). This study began because each author had seen a cohort of males with MPD and dissociative disorders, in particular in the VA hospital system (RJL) and the state hospital system (FWP). We describe a systematic assessment of these patients, compar-

ing them with female patients in the NIMH data base on MPD. Areas of particular focus between the male and female samples include comparison of clinical history, phenomenology, symptom profile, history of violence and/or involvement with the criminal justice system, and histories of childhood abuse and/or trauma.

Literature Review

Multiple personality disorder is now generally conceptualized as a childhood-onset, dissociative post-traumatic disorder (Kluft, 1988; Putnam, 1989). Very high rates of childhood traumatization have been described in virtually all modern systematic studies of MPD, usually severe, repetitive physical and/or sexual abuse generally beginning before the age of five (Kluft, 1988; Putnam, 1989; Ross 1989). In MPD, it is now thought that dissociative states are mobilized to protect the child from the full impact of overwhelming early trauma (Kluft, 1988; Putnam, 1985, 1989). Secondary structuring of these altered states leads to the development of the MPD "personalities" (Kluft, 1988; Putnam, 1989). In addition to the alter personalities, most MPD patients demonstrate chronic complex dissociative symptoms such as amnesia, spontaneous trances, depersonalization, and spontaneous age regression, as well as post-traumatic stress symptoms (Kluft, 1988; Loewenstein, Hornstein, & Farber, 1988; Putnam, 1989).

Compared to female MPD patients, relatively little systematic data has been collected on males with MPD and other dissociative disorders. However, males with MPD have been described since the first MPD cases were reported (Ellenberger, 1970, Taylor, & Martin, 1944; Sutcliffe & Jones, 1962). Male MPD cases have continued to be reported in the modern professional and popular literature, either singly or as part of larger series of cases (see for example, Allison, 1980, 1981-1982; Bliss, 1984, 1986; Bliss & Larson, 1985; Carlisle, 1986; Coons, Bowman, & Milstein, 1988; Keyes, 1981; Kluft, 1984; Ludwig, Brandsma, Wilbur, Bendfeldt, & Jameson, 1972; Loewenstein, Putnam, Duffy, Escobar, & Gerner, 1986; Putnam, Loewenstein, Silberman, & Post, 1984; Ross & Norton, 1989). Prevalence figures for males among patients with MPD have ranged from 8.0% in a study of 100 cases of MPD (Putnam, Guroff, Silberman, Barban, & Post, 1986) to 31.4% in a cohort of 70 MPD patients (Bliss, 1984, 1986). However, the sex ratio for childhood MPD cases in the current literature is reported to be about 1:1 (Vincent & Pickering, 1988).

Only a few studies have looked systematically at a series of males with MPD. Bliss (1984, 1986; Bliss & Larson, 1985)

published data on 22 males and 48 females with MPD all of whom met DSM-III criteria for MPD (American Psychiatric Association, 1980) and who completed a 327-item self-report inventory. Both males and females were markedly polysymptomatic. Females were significantly more likely to have obsessive-compulsive symptoms, phobic symptoms, anxiety, and "hysteria." Males displayed significantly more antisocial behavior and alcoholism than females. Very high hypnotizability scores on standardized scales were noted for both male and female MPD patients.

Ross and Norton (1989) described 236 patients with MPD reported on by 203 Canadian and U.S. clinicians with a 36-item questionnaire. Patients were said to meet DSM-III and NIMH research criteria for MPD. Twenty-eight male MPD patients (11.9%) were found in this sample. Males did not differ from females on most variables including frequency of a history of childhood physical and sexual abuse. Numbers and types of personalities were not significantly different between the two groups. Females had significantly more depressive symptoms than males and were significantly more likely to engage in overdoses and certain types of self-mutilation. Significantly more males had been convicted of a crime and jailed, although over 70% of men had not engaged in criminal activity. Rates of substance abuse were said to be similar between the two groups.

Several hypotheses have been advanced to explain the discrepancy in the prevalence figures between male and female multiples. There is a long-standing association in the literature between violent behavior and male MPD dating back at least to the 1828 case of Sorgel who was described as having one pious, "decent" personality and another who was a savage, vicious murderer (Taylor & Martin, 1944). This has contributed to the speculation that males with MPD are underrepresented in the clinical literature since they are more likely to engage in interpersonal violence than female multiples, and thus find their way into the criminal justice system instead of the mental health system (Allison, 1980, 1981-1982; Bliss & Larson, 1985; Kluff, 1988; Putnam, 1989; Ross & Norton, 1989).

The popular MPD literature over the last century has tended to perpetuate this stereotype. Robert Lewis Stevenson's *The Strange Case of Dr. Jekyll and Mr. Hyde* (1886) was the most famous of numerous late 19th century literary works with a theme of crimes committed primarily by males resulting from somnambulism, multiple personality, and/or hypnosis (Ellenberger, 1970). More recently, popular biographical accounts about male multiples such as *The Minds of Billy Milligan* (Keyes, 1981) and *The Five of Me* (Hawthorn & Schwartz, 1977) have emphasized the protagonists' violent and/or criminal behavior (see also Allison, 1980).

Further, Kenneth Bianchi, one of the "Hillside Strangers" and a confessed multiple murderer, attempted to obtain a verdict of not guilty by reason of insanity (NGRI) due to alleged MPD (O'Brien, 1985). A controversy persists among the experts who testified during the trial about malingering versus true MPD in Bianchi (Allison, 1984; Orne, et al., 1984; Watkins, 1984). Whatever Bianchi's actual diagnosis, however, transcripts of audio and video taped interviews by defense experts with Bianchi suggest that they did not adequately

comprehend the nature of a forensic assessment and woefully misunderstood Bianchi's desire to evade a conviction by any means possible (Allison, 1984; O'Brien, 1985). Howe (1984) and French and Shechmeister (1983) have discussed the evaluation of allegations of MPD in a forensic setting.

Kluft (1986) has emphasized that male multiples tend to differ phenomenologically from females especially with respect to the greater subtlety of the clinical presentation. Compared with females, male multiples generally showed fewer overt differences between alters with switching and only infrequently developed complex inner worlds (Putnam, 1989). According to Kluft (1988), male MPD is even less likely to be diagnosed than the often-misdiagnosed female cases due to low index of suspicion and the lack of appreciation of the counterexpectational nature of the clinical presentation.

The lower prevalence of male MPD patients may also be due to the different rates of child abuse reported for males and females. The epidemiological data suggests that, in our culture, females are more likely to be sexually abused than are males. Current studies of non-clinical samples suggest that two to three girls will be sexually abused for every boy, although rates of reported sexual abuse among males are increasing (Bolton, Morris, & MacEachron, 1989; Finkelhor, 1984, 1986, 1987). Males and females are usually reported to have similar overall rates of physical abuse in childhood (Leventhal & Midelfort, 1986). However, boys are reported to be physically abused five times more frequently than girls from birth to two years old, and three times more frequently from three to five years old—the age range when MPD is generally thought to first develop (NCCAN, 1981; Putnam, 1989).

METHODS

Clinical Assessment

Patients primarily came to the authors in consultation with a request to evaluate them for a dissociative disorder. Most patients came from the clinical services of the West Los Angeles VA Medical Center (RJL) and St. Elizabeth's Hospital, Washington, D.C. (FWP), although several patients came from other private and public settings. No patient was facing current legal charges at the time of evaluation nor were any evaluations performed as part of a medico-legal assessment.

In general, patients had extensive prior treatment histories and most had already undergone a complete negative neurological and neuropsychiatric investigation to rule out organic causes of their symptoms. Work-up had generally included neurobehavioral examinations, EEGs, including sleep-deprivation and naso-pharyngeal leads, CT scans, and MRI scans.

Each patient underwent a detailed semi-structured interview designed to yield diagnoses of dissociative disorders by DSM-III/DSM-III-R and NIMH research criteria (American Psychiatric Association 1980, 1987). NIMH research criteria specify that, in addition to DSM-III/DSM-III-R criteria for MPD being satisfied, two or more alter personalities must exhibit distinct alter-personality-specific-behavior on at least three separate occasions, and that psychogenic amnesia is reported or observed.

Interviews inquired about amnesia symptoms, auto-hyp-

notic symptoms, post-traumatic stress symptoms, somatoform symptoms, and symptoms related to possible alter personalities such as passive-influence symptoms and switching phenomena. Formal induction of hypnosis to establish the diagnosis of MPD was not used in most evaluations. In addition, 15 male patients completed the Dissociative Experiences Scale (DES) a valid and reliable self-report inventory for dissociative symptoms (Bernstein & Putnam, 1986).

Data Collection

For each male patient (N=21), the authors completed a 386-item NIMH questionnaire describing characteristics of the patients (Coons et al., 1988; Putnam et al., 1986). Data on the male MPD patients were compared with that in the NIMH data base on 92 female MPD patients characterized in a previous questionnaire study (Putnam et al., 1986). DES data for the males were compared with DES data on a separate sample of 36 female patients meeting NIMH criteria for MPD.

Behavior and symptom arrays, created by grouping related questionnaire items, were used in some data analyses. Parametric and non-parametric group comparisons between male and female multiples were analyzed by t-tests, Chi Square and Kruskal-Wallis. The appropriate Bonferroni correction factor for multiple variables was applied for all analyses (Grove, 1986). The Bonferroni correction is applied to multiple comparisons to correct for the tendency of large numbers of comparisons to produce "significant" differences by chance. Comparisons between males and females were also performed after symptoms were grouped into indices containing process, amnesia, auto-hypnotic, somatoform, post-traumatic, and affective items following the typology of Loewenstein et al. (1988).

RESULTS

Due to the large number of variables and the use of the Bonferroni correction, few significant differences emerged between the male and female MPD patients. Overall, the similarities between the male and female patients were far more marked than the differences. Further, few significant differences emerged when symptoms were grouped into the symptom cluster typology of Loewenstein et al. (1988) for comparison between the male and female subsamples. Nonetheless, some trends did emerge showing differences between the male and female MPD patients.

FIGURE 1

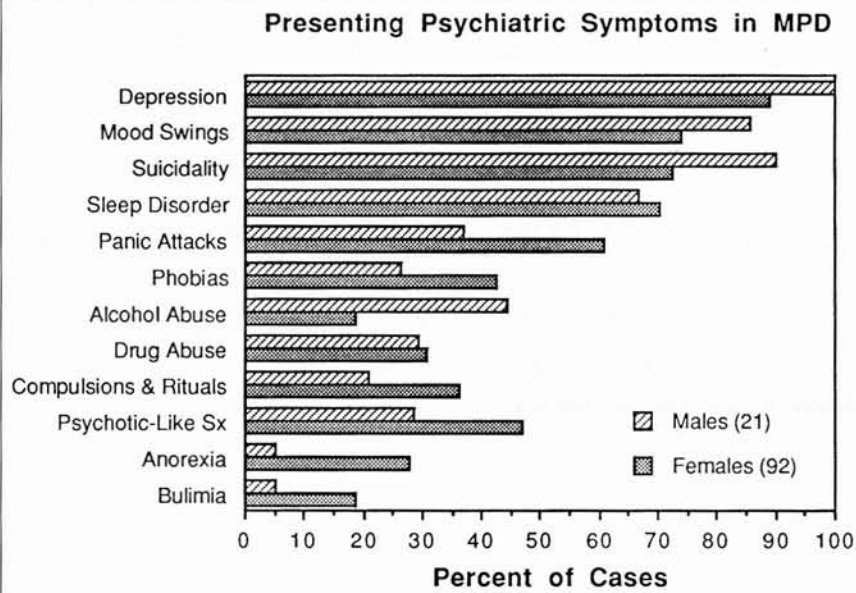
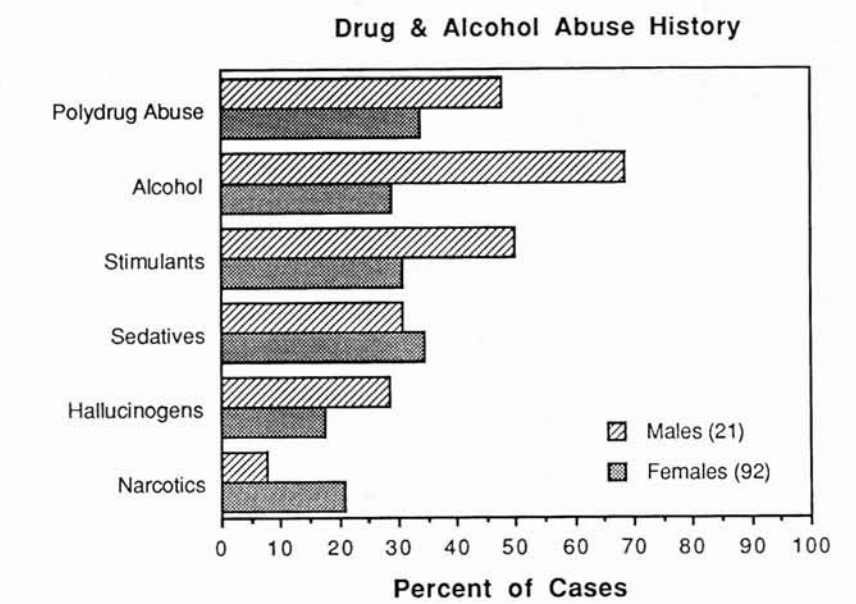


FIGURE 2



Demographic Data

There were no significant differences between the three samples in age (males mean age = 38.6, SD 10.89; females mean age = 34.40, SD 8.01, p = NS) or mean Hollingshead-Redlich 4-factor socio-economic status (males mean SES = 35.31, SD 13.01; females mean SES = 32.57; SD 16.04, p = NS). The mean SES of both groups is considered to be in the "blue collar" range.

FIGURE 3

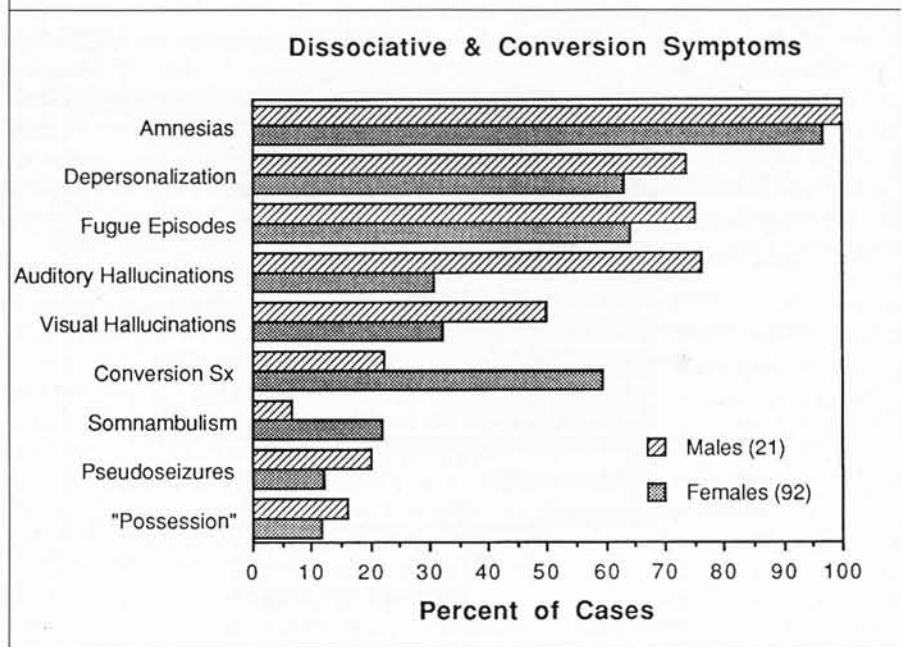
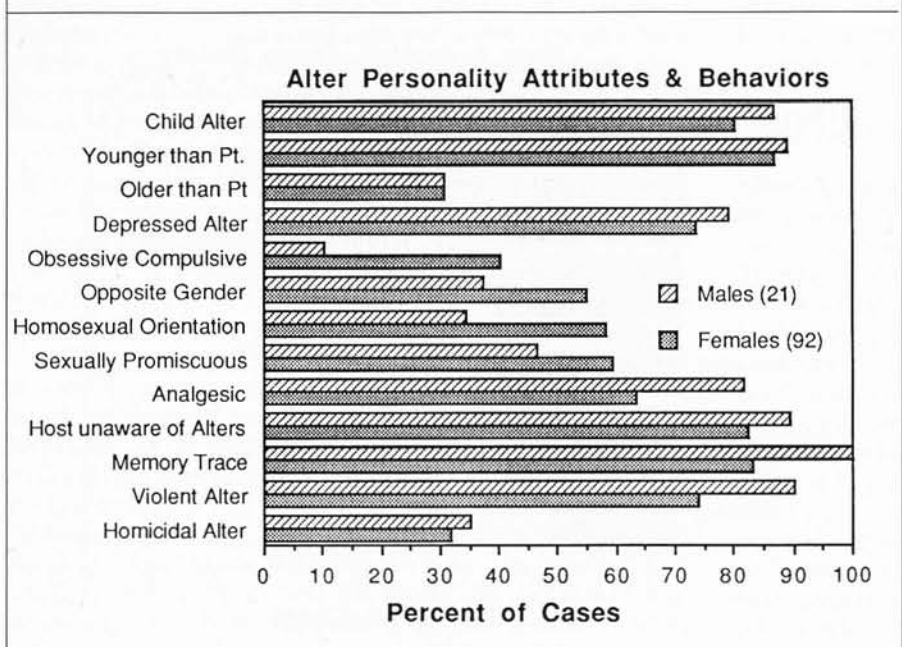


FIGURE 4



Presenting Psychiatric Symptoms

Both males and females were markedly polysymptomatic and showed high levels of the same symptoms (mean number of presenting symptoms; males = 16.7; females = 18.6, $p = NS$). Both groups had long prior psychiatric histories. Males had received an average of 3.90 prior diagnoses before the diagnoses of MPD was made as compared with 3.61 prior diagnoses for females ($p = NS$).

Figure 1 shows the most common presenting psychiatric symptoms in the male and female comparison groups. In particular, both groups reported high percentages of "affective-like" symptoms with depression, mood swings, suicidal behavior, and sleep disturbances among the most common presenting symptoms. There was a trend for females to have more panic attacks, compulsions and rituals, and eating disorders.

Polysubstance abuse was very common in both male and female MPD patients. Figure 2 shows the trends for different types of substance abuse between males and females. There was a particularly strong trend for males to abuse alcohol more frequently than females, although the overall rates of drug abuse were similar in the two groups.

As shown in Figure 3, males and females look quite similar with respect to reported frequency of most dissociative symptoms such as amnesia, fugues, and depersonalization. There was a trend for females to show more conversion symptoms, although males more frequently had a history of pseudoseizures. There was a trend for males to report more hallucinatory experiences.

The Alter Personality Systems

There were no significant differences between the males and females in frequency of types of alter personalities such as child, opposite sex, analgesic, depressed, opposite gender, alters reporting themselves as younger or older than the chronologic age of the person, etc. (see Figure 4). About 90% of the males and 74% of the females reported the presence of a violent alter ($p = NS$); 35% and 32% respectively reported the presence of a homicidal alter ($p = NS$).

We noted no significant differences between the two samples in attributes and behaviors said to be localized in the alter personalities or symptoms due to interaction or interference between the alters. Men and women reported similar frequencies of phenomena such as co-consciousness, intra-consciousness, hidden observer, internal conversations, and speed of switches.

Figure 5 shows that both male and female MPD patients reported that alter personalities showed high frequencies of different and/or compartmentalized physical symptoms, skills and knowledge, and handedness, as well as differential responses to foods, medicines, drugs, and allergens.

Significant differences did emerge, however, between males and females with respect to the numbers of alter

personalities and the age that personalities were first said to have appeared. Male MPD patients averaged 7.2 alters with a median of 5 (range 2-22). Female MPD patients averaged 19.1 alters with a median of 12.5 (range 1-99) ($F = 14.48, df = 75.14, p < .0001$). The retrospective recall of the average age at first appearance of a personality was reported as 6.62 years for males (median = 5, range 2-13) versus 7.85 for females (median = 5, range 2-14) ($F = 13.36, DF 54,15p < .0023$).

Violence Towards Self and Others

As shown in Figure 6, threatened or actual violence towards self and others is common in MPD patients. Suicidal behavior was very common among both males and females with MPD. Violent, persecutory, and "internally homicidal" activities of alters against one another were described in about 60% of MPD patients, male and female alike. The latter phenomena accounts for apparent suicidal or self-mutilating behavior in MPD patients. There was a trend for females to have more frequent self-mutilation than males.

About 19% of the males and 7% of the females reported the successful perpetration of a homicide ($p = NS$). About 47% of the males and 35% of the females reportedly engaged in criminal behavior ($p = NS$). The males reporting criminal behavior all had been incarcerated for at least a brief period of time. We do not have data on the frequency of incarceration for the females. There was a trend for alcohol-related offenses and problems such as drunk driving to be more common in males.

Child Abuse/Childhood Trauma/Adult Trauma

As shown in Figure 7, both groups reported similarly high percentages of childhood abuse, trauma and victimization without significant differences or trends between them. Only one male patient and three female patients did not describe a history of childhood trauma. Males averaged 2.95 childhood trauma items reported per patient compared with 3.20 for females ($p = NS$).

Overall, 85% of the males and 93% of the females described a history of childhood sexual abuse. About 62% of the males and 79% of the females reported a history of repeated childhood sexual abuse while 23% of the males and 15% of the females reported a single episode of childhood sexual abuse.

In addition to high rates of physical abuse, neglect and

FIGURE 5

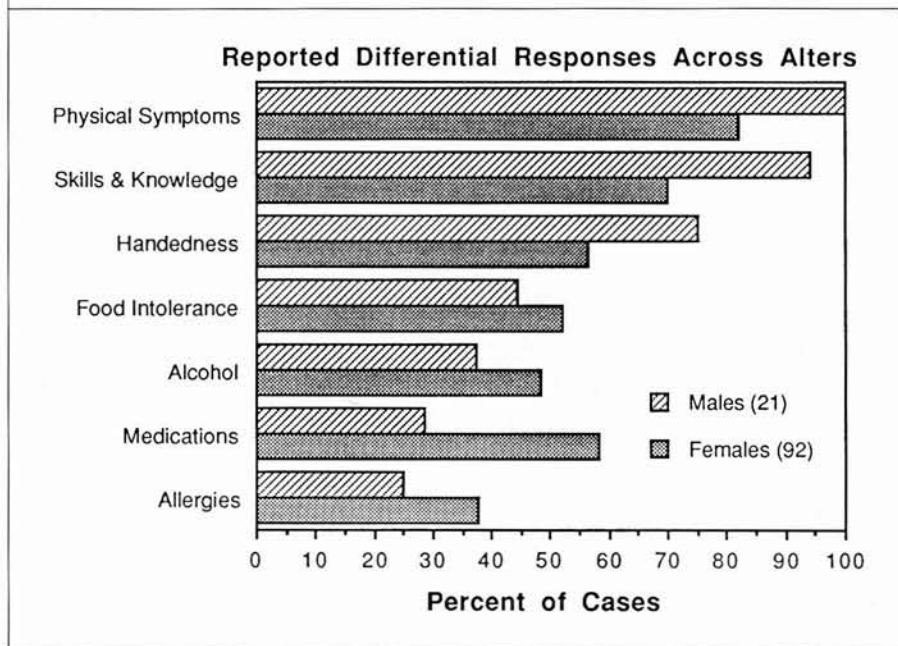
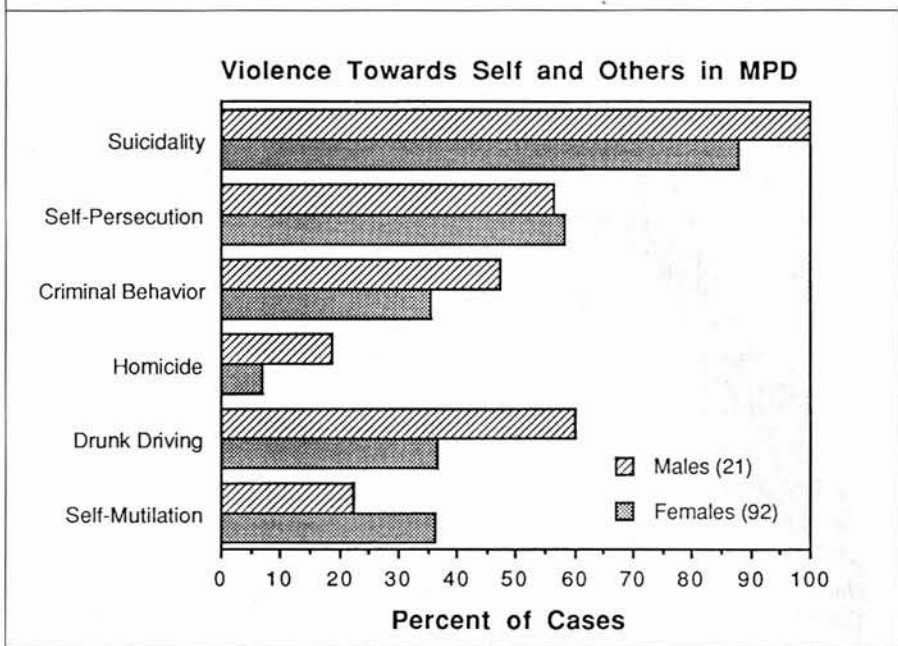


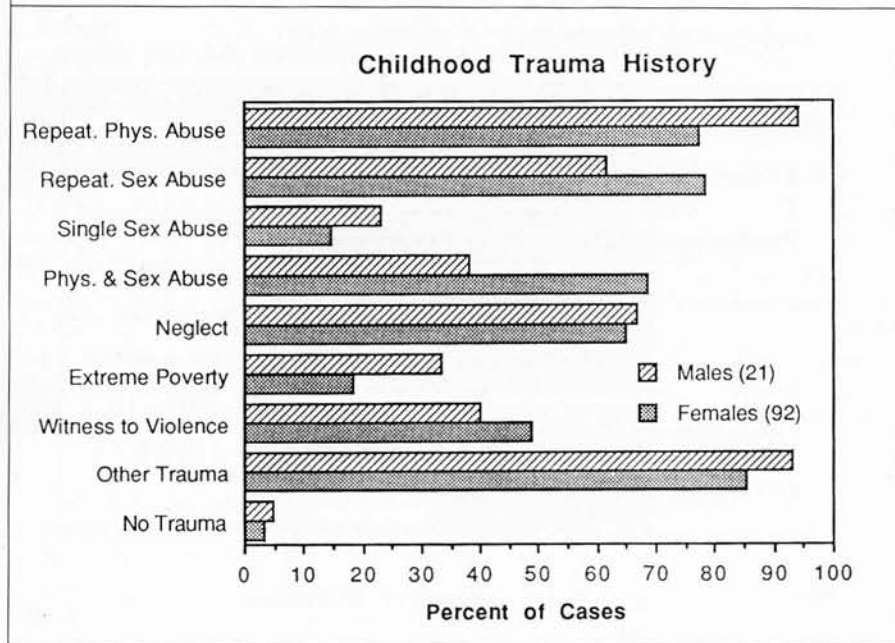
FIGURE 6



exposure to violence, over 85% of males and 93% of females reported other types of trauma, such as confinement abuse (e.g., being locked in closets, basements, coffins, etc.), prolonged painful medical procedures, severe emotional abuse, subjection to bizarre health practices (e.g., repeated enemas), etc.

With respect to adult victimization, there was a robust trend for females (57.7%) compared to males (16.7%) to report being the victim of rape as an adult ($Chi Sq = 6.973,$

FIGURE 7



df = 1, P = .0083, p < .00081 is needed for statistical significance after the application of the Bonferroni correction for 61 comparisons).

DES Data

Males (N = 15) and females from the second NIMH sample (N = 36) showed no significant differences in age or demographic data. Median DES score for males was 48.75 compared with 56.25 for females (p = NS). Normals had a median score of 4.36 on the original validation study for the DES (Bernstein and Putnam, 1986). There were no significant differences comparing the two groups on the amnesia, depersonalization, and absorption subscales of the DES. After application of the Bonferroni correction factor, there were no significant differences in the scores on any individual DES item between the males and the females.

DISCUSSION

First, we wish to address some of the methodological limitations of this study. (1) The male patients were drawn from a sample seen in clinical consultation and diagnoses were not originally made in a research context. Most patients were not followed up longitudinally. (2) Because of the clinical nature of the assessments, interrater reliability was not established for the interviews. The authors, however, have previously collaborated extensively including blind and non-blind evaluation of the same patients and have a high rate of concordance in the diagnosis of MPD. (3) Three different samples are being compared: a clinical male MPD sample, a questionnaire sample of 92 female MPD patients described by a large number of clinicians, and a research sample of 36 female MPD patients studied with the DES.

Thus, the results we report should be considered preliminary and in need of more rigorous replication. Nonetheless, many of our findings are quite compelling since few differences were found between the three patient groups despite the differing methodologies used to assess them. Also, our data are consistent with other data about MPD patients in the literature (Kluft, 1988; Putnam, 1989; Ross, 1989). Our findings enhance the robustness of the MPD construct since a valid diagnostic category should show relatively good overlap among males and females in etiology, course, phenomenology, natural history, etc.

Phenomenology

As described in prior studies, both male and female MPD patients present in a polysymptomatic fashion with a predominance of amnesia, affective, anxiety, somatoform and pseudo-psychotic symptoms (Bliss, 1986; Coons et al., 1988; Kluft, 1988; Putnam, 1989; Putnam et al., 1986). Due to this, both groups of patients had received

numerous prior diagnoses and spent long, relatively unproductive periods of time in the mental health system before the MPD diagnosis was made. It should be emphasized that our male patients generally had extensive histories of mental health treatment, even among those who had histories of incarceration for criminal behavior.

In addition, the structure of the multiplicity was similar among males and females. The same types of personalities were found in both sexes with essentially equal frequencies. Male and female multiples showed almost no differences in attributes, characteristics and behaviors of the MPD alternates. Complex dissociative processes such as speed of switching, co-consciousness, hidden observer phenomena, and compartmentalized skills and handedness were described with similar frequencies in the men and the women.

Although based on a different sample group comparison, the DES data are quite similar between the male and female multiples and quite consistent with those in the validation study of the DES and subsequent replications by other investigators (Bernstein & Putnam, 1986; Coons et al., 1988; Ross et al., 1988). The DES provides an objective correlate for the clinical findings and supports the notion that the same disorder is being characterized in males and females.

On the other hand, we did identify some trends for significant differences between males and females. We found higher reported frequencies of conversion symptoms, phobias, obsessive-compulsive symptoms, self-mutilation, and eating disorders in females and higher percentages of alcoholism, reckless driving, and criminal behavior in males. It is unclear whether these data suggest fundamental differences between male and female MPD patients. It is more likely that these findings merely highlight general differences in symptoms between males and females in our culture (Kluft,

1988). In addition, since our patients primarily came from lower socio-economic groups, social class may be a factor in the high frequency of substance abuse and antisocial behavior in these patients. To clarify this point, further research is needed comparing MPD patients from various socio-economic groups to each other and to other clinical groups, including non-MPD patients with histories of childhood abuse. However, several recent studies suggest that child abuse histories are common in alcoholics and drug abusers and that such histories are associated with greater psychiatric morbidity and intensity of psychiatric symptoms (Schaeffer, Sobieraj, & Hollyfield, 1988). These findings support the observation of Kluft (1985) that male multiples may be frequently found in substance abuse treatment settings.

These data do support the clinical observation, that male MPD patients are likely to present with a somewhat less florid symptom profile than females. Male multiples reported significantly fewer personalities than did the females (mean of 7.2 versus 19.1 respectively). However, our female sample had been followed longitudinally for some time so it might be anticipated that more personalities were found in this group. Nonetheless, our data are consistent with the clinical impressions of Kluft (1984, 1986) and the preliminary NIMH data (Putnam, 1989) suggesting that most male MPD patients have fewer personalities and less complex inner worlds than the females. On the other hand, the Ross and Norton study (1989) found no significant difference in number of personalities between male and female MPD patients.

Overall, our clinical impression is that most of this group of male patients showed less complex development of alter personality systems than typical female patients. In addition, notable presentational differences among the alters such as wardrobe, accent, posture, etc. was less common among these male patients than among female MPD patients previously studied by the authors. However, about 20% of males in this sample were quite similar to the females in these respects. Further research will be necessary to clarify this issue.

Childhood and Adult Abuse and Trauma

Virtually all patients in both the male and female groups reported histories of childhood trauma and abuse. These patients described abuse histories far more frequently than would be expected from community or even ordinary clinical samples (Bolton, Morris, & MacEachron, 1989; Finkelhor, 1984, 1986, 1987; Bryer, Nelson, Miller, & Kroll, 1987). In addition, the abuse histories in both groups primarily consisted of multiple forms of repetitive child abuse beginning at an early age.

In particular, the male multiples in this study report remarkably high percentages of childhood sexual abuse, especially compared to general population samples of men (Bolton et al., 1989; Finkelhor, 1984, 1986, 1987). This finding is even more notable since most of our male patients were seen relatively briefly in consultation. Males may be even more reticent than females to acknowledge histories of childhood or adult sexual abuse or victimization and even more likely to minimize the impact of these events even if

they do admit to them (Bolton et al., 1989; Russell, 1984). In addition to the histories of childhood sexual abuse, large percentages of the male patients reported childhood histories of physical abuse, neglect, witness to violence or murder, and other bizarre forms of abuse such as repeated enemas, confinement abuse, witnessing pets slaughtered as a form of punishment, denial of food as a punishment, etc.

With respect to adult trauma, close to 60% of the female sample group were reported to have suffered an adult rape. About 17% of the males also described being raped as an adult. Both of these figures are higher than those reported for community samples on the prevalence of rape, although the data on rape of males is very limited (Russell, 1984). Coons and Millstein (1986) have described a significantly higher frequency of adult rape in a sample of female MPD patients as compared to a non-MPD control group.

Histories of Criminal Behavior

Although males in our study reported more homicidal and criminal behavior than did females, the differences were not significant. In this regard, our data on antisocial behavior are different from those reported by Bliss (1984) and by Ross and Norton (1989) who found statistically significant differences between males and females with respect to criminal and/or antisocial behavior.

Our male sample had three subgroups with respect to criminal behavior. The largest subgroup reported no criminal behavior at all. Another had been engaged in minor crimes such as fighting, disorderly conduct or public drunkenness. If jailed, these individuals had served relatively brief sentences in county or city jail. A third male subgroup had engaged in serious crimes of violence (armed robbery, rape, murder) and had served longer sentences in state prisons or institutions for the criminally insane.

About 19% of our male group reported perpetrating a homicide and about 13% described committing a rape. Our female sample was quite violent as well, however, with almost 10% reporting perpetration of a homicide and about one-third describing criminal behavior. Males and females in our study showed no significant differences in reported prevalence of violent and/or homicidal alters. Unfortunately, we have little data in either of our samples on rates of perpetration of child abuse or spouse abuse by male and female multiples. As noted above, however, social and demographic effects may be a factor in these findings.

Taken together, however, these findings suggest an alternative to the received wisdom that male MPD patients are primarily found in violent prison populations. Among those male MPD patients who have perpetrated crimes, many will have successfully served their sentences and returned to the community. In general, many prisoners in the American penal system, even violent ones, serve prison terms considerably shorter than the maximum due to the parole and sentence reduction procedures built into the penal system. A particularly violent, recidivist subgroup of male multiples may have longer incarcerations, however (Carlisle, 1986).

On the other hand, the relatively high prevalence of violent and criminal behavior in male MPD patients is consistent with several studies indicating that a history of phys-

ical and sexual abuse as a child is an important variable in the development of violent, aggressive, and/or homicidal behavior in males (Burgess, Hazelwood, Rokous, & Hartman, 1988; Dixon, Arnold, & Calestro, 1978; Feldman, Mallouh, & Lewis, 1986; Lewis et al., 1985). Future studies on male and female multiples should attempt to understand the factors that lead to the development of violent or criminal behavior in some MPD patients and not in others.

CONCLUSIONS

The phenomenology, clinical history, and history of antecedent severe child abuse are very similar between male and female MPD patients. The high prevalence of child abuse experiences in our male sample is consistent with the findings of all other systematic studies of male and female MPD patients (Bliss, 1986; Coons et al., 1988; Kluff, 1988; Putnam, 1989; Putnam et al., 1986; Ross, 1989; Ross & Norton, 1989). Our findings strongly support the notion that, in both males and females, MPD is a childhood-onset, post-traumatic dissociative disorder etiologically related to severe childhood trauma.

The actual prevalence of males among all MPD patients is unknown. Our data suggest that male MPD patients may not have been adequately represented in previous clinical studies. This is probably due to clinicians' low index of suspicion that males can have dissociative disorders, the belief that male MPD patients are only found in prison settings, little awareness of the subtlety of the clinical presentation in most male MPD patients, and the relative lack of systematic inquiry about histories of childhood abuse in males in general clinical samples. In addition, a large subgroup of male multiples is likely to show alcohol abuse and related problems. Screening for dissociative symptomatology and histories of child abuse are clearly warranted for all patients in substance abuse treatment.

On the other hand, additional research is warranted to clarify discrepancies among the studies comparing male and female MPD patients. Social and demographic factors need to be more rigorously controlled in future studies comparing men and women with MPD. It is likely, however, that as our awareness of the extent of child abuse in non-clinical and clinical populations, male and female alike, increases, we will continue to find more male MPD patients. ■

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