

THE DIFFERENTIATION OF PATIENTS WITH MPD OR DDNOS FROM PATIENTS WITH A CLUSTER B PERSONALITY DISORDER

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ABSTRACT

Because of similarities in presentation, multiple personality disorder (MPD) and dissociative disorder not otherwise specified (DDNOS) can be misdiagnosed as borderline personality disorder (BPD) or another cluster B personality disorder. In order to find distinguishing symptoms, four groups of patients are compared: DDNOS patients (N=24); MPD patients (N=49); patients with BPD or histrionic personality disorder, referred for evaluation of dissociative pathology (N=21); control patients with a cluster B personality disorder (N=19). All patients were interviewed with the Structured Clinical Interview for DSM-III-R Dissociative Disorders (SCID-D) and the Structured Trauma Interview (STI).

Although there are many areas of overlap in the phenomenology of patients with MPD or DDNOS and patients with a "cluster B" personality disorder, we clearly found that these groups can be differentiated by the severity and cluster of dissociative symptoms, the prevalence of some Schneiderian symptoms, and the severity of childhood trauma.

INTRODUCTION

The aim of this study concerns the differentiation of multiple personality disorder (MPD) and dissociative disorder not otherwise specified (DDNOS), from borderline personality disorder (BPD) and other cluster B personality disorders (i.e., the antisocial, histrionic, and narcissistic personality disorders in *DSM-III-R* [American Psychiatric Association, 1987, p. 337]). The distinction between these disorders is important because in a majority of patients with MPD or DDNOS in the Netherlands, the dissociative disorder

goes undetected and these patients are diagnosed as BPD or one of the other cluster B personality disorders. This is not surprising, as phenomenologically there is a considerable overlap of symptoms between and among these disorders (Horevitz & Braun, 1984; Putnam, Guroff, Silberman, Barban, & Post, 1986; Kluft, 1987a, 1987b; Fink & Golinkoff, 1990; Ross, Heber, Norton, & Anderson, 1989; Fink, 1991). Moreover, several studies have shown MPD patients often have a co-existing BPD diagnosis (Horevitz & Braun, 1984; Ross, et al., 1990). Etiologically there is a strong relationship between MPD as well as BPD and traumatic experiences and neglect in childhood, although in general the prevalence rates of childhood trauma among BPD patients are lower than among MPD patients. For BPD we refer in this respect to the studies of Herman, Perry, and van der Kolk (1989), Zanarini, Gunderson, Marino, Schwartz, and Frankenberg (1989), Ogata, Silk, Godrich, Lohr, and Westeen (1990), and Shearer, Peters, Quaytman, and Ogden (1990), and Raszek (1992), among others. For MPD, empirical data were provided by Bliss (1986), Putnam et al. (1986), Coons, Bowman, and Milstein (1988), Loewenstein and Putnam (1990), Ross et al. (1991), and Draijer and Boon (1993) provided data on the relationship with childhood trauma.

Despite all the apparent similarities in presentation, the question is to which extent are MPD (or DDNOS) and BPD phenomenologically and etiologically similar. Can they be differentiated? Some authors consider MPD as a specific type of borderline personality organization, implying similarities between identity fragmentation and splitting (Clary, Burstin, & Carpenter, 1984; see also Fink, 1991). Horevitz and Braun (1984) found MPD to be a distinct disorder, although 70% of the thirty-three MPD patients met *DSM-III* criteria for borderline personality disorder. Kemp, Gilbertson, and Torem (1988) compared ten MPD and ten BPD persons. They found a marked degree of pathology — suicide attempts, eating disorders, sleep disorders, substance abuse — for both groups, but no statistical differences on psychopathology, historical, demographic, and psychological testing variables (such as the MMPI). They suggest that a memory disturbance might be the key difference between the two groups. Comparing the three diagnostic groups of schizophrenia, BPD and MPD, using a broad battery of psychological tests and a series of structured interviews, Fink and Golinkoff (1990) found that MPD was not differentiated from BPD on MMPI and MCMI, but that these groups of patients differed in clinical features, such as dissociative symptoms and the number of Schneiderian symptoms, as well as in etiologically relevant characteristics such as the severity of childhood abuse. In our preliminary

study with the SCID-D, we found some distinguishing features between MPD and BPD, in particular amnesia. But group sizes were too small to be able to draw more definite conclusions (Boon & Draijer, 1991).

The present research compares findings on four groups of patients: two groups of patients with a dissociative disorder, and two groups of patients with a cluster B personality disorder. The four groups are compared on the prevalence and severity of dissociative symptoms, the prevalence of some Schneiderian and psychotic symptoms, the prevalence of suicidality, self-mutilation, and symptoms of PTSD, and the prevalence of reported experiences of child abuse.

METHOD

Instruments

All the patients were interviewed with the Structured Clinical Interview for *DSM-III-R* Dissociative Disorders (SCID-D); the Structured Trauma Interview (STI) was administered after the SCID-D.

The SCID-D is a semi-structured diagnostic interview for the assessment of *DSM-III-R* Dissociative Disorders (Steinberg, Rounsaville, & Cicchetti, 1990; Steinberg, 1993). Five dissociative symptom areas — amnesia, depersonalization, derealization, identity confusion, and identity alteration — are evaluated. In the preliminary study mentioned, reliability rates were in the good (.60) to excellent (.95) range. A Dutch validation study confirmed these results (Boon & Draijer, 1991, 1993).

The Structured Trauma Interview is based on a structured interview developed by Draijer (1988) and consists of a set of questions on childhood and adult sexual and physical trauma and related symptoms, such as self-mutilation, suicidality, eating disorders, and post-traumatic stress disorder (PTSD), as well as symptoms of borderline personality disorder (BPD) and histrionic personality disorder. This part of the interview was administered after the SCID-D. All interviews were conducted by the authors and audiotaped or videotaped. Informed consent, including consent to video and audiotaping, was obtained from all patients.

In all dissociative disorder patients there is at least one follow-up within a year. In most cases there are follow-up data ranging from one to four years. Follow-up data were gathered in three ways: (1) All treating clinicians completed a structured questionnaire about treatment histories, abuse histories, and prior diagnoses; (2) By talking to these clinicians during consultations with regard to treatment issues; or (3) By consultations with both patient and clinician regarding treatment issues.

Thus, data on childhood trauma of patients with a dissociative disorder are based on the Structured Trauma Interview and on the reports of the referring clinician. Additional information on all the patients with a personality disorder was not obtained systematically; data on childhood trauma in these patients are based on the structured trauma interview.

The control group was diagnosed prior to the research interview by an independent psychiatrist with the Present State Examination (PSE) (Wing, Cooper, & Sartorius, 1974)

and the Structured Interview for *DSM-III* Personality Disorders (SIDP-R) (Pfohl, Stangl, & Zimmerman, 1982).

Subjects

Four different groups of patients participated in this study: (I) Patients with DDNOS (N=24); (II) Patients with MPD (N=49); (III) Patients with BPD or histrionic personality disorder, who were referred for evaluation of dissociative pathology (N=21) — a dissociative disorder was ruled out at the research interview — (We refer to this group as group III, or "cluster B consult"); (IV) Patients with a cluster B personality disorder from a psychiatric control group — a dissociative disorder was also ruled out at the research interview — (We refer to this group as group IV, or "cluster B control"). These four groups are compared with the intention of trying to define their distinguishing features.

Of the patients with DDNOS and MPD (group I and II), fifty were originally diagnosed by their treating clinician and referred to us to participate in one of our studies. The others (N=23) were referred for evaluation because a dissociative disorder was suspected by their therapist. The diagnosis of a dissociative disorder was made at the research interview. These diagnoses were independently confirmed at the follow-up. It is important to note that at follow-up, almost all patients in our study with DDNOS met criteria for MPD (we have follow-up data on twenty of the twenty-four patients with DDNOS; nineteen of these twenty patients met criteria for MPD at follow-up).

Group III (N=21) consisted of patients who had received diagnoses of BPD (N=19) or histrionic personality disorder (N=2) by their referring clinicians. These patients were referred by their treating therapist for evaluation of dissociative symptoms. At the research interview a dissociative disorder was ruled out, although a majority of this group (76.2%) reported severe and chronic depersonalization and, in fact, met criteria for depersonalization disorder. This diagnosis was not given because, according to *DSM-III-R*, depersonalization is considered to be a symptom of a personality disorder.

Group IV (N=19) consisted of patients who had participated in the psychiatric control group of the validation study on the SCID-D (Boon & Draijer, 1993). A selection of patients was taken from this group, those meeting criteria for BPD (N=8), histrionic personality disorder (N=4), or personality disorder NOS (N=7) (with borderline, histrionic, narcissistic, or antisocial features). A diagnosis of dissociative disorder was ruled out at the research interview.

Statistics

Differences between the four groups were tested on the severity of the dissociative symptoms measured by the SCID-D and on the prevalence and severity of trauma. One-way analysis of variance was conducted to determine whether there were overall group differences in SCID-D scores or in severity ratings of trauma. Overall differences in prevalence of separate dissociative symptoms and other trauma-related symptoms, such as self-destructiveness and eating problems, were tested using Chi²-tests. Differences between the separate groups are described.

RESULTS

Demographic Characteristics and Treatment Setting

The four groups of patients did not differ in age, marital status, or educational level. The mean age was 32.8 (SD=9.21; range 15-57); 54.9% had never been married; 25.7% were married, and 19.5% were divorced. Of all the patients, 13.3% had one child, 12.4% had two children, 12.4% more than two, and 61.9% of the patients were childless.

Although the patients did not differ in level of education, there were slight, but significant differences in their current employment setting ($\chi^2=10.27$; $df=3$, $p<.05$). Of all the patients, only 23% had a job at the time of the research interview. Only 12% of the MPD patients were employed, 29% of patients with DDNOS, and 19% of group III. By contrast, almost half of group IV was employed at the time of the interview (49%).

The patients did not differ in treatment setting. Of all the patients, 73.5% were outpatients, and 26.5% inpatients at the time of the research interview. The groups did not differ in the age at which their first contact with the mental health system had taken place: the mean age was 23.74 (SD=8.83; range 9-53).

Comparison of the Severity of Dissociative Symptoms Among the Four Different Groups

Table 1 shows a comparison of the severity of dissociative symptoms—amnesia, depersonalization, derealization, identity confusion, and identity alteration—among the four groups.

The four groups differed significantly in severity of each of the five dissociative symptoms, and total SCID-D score. Each of the tests yields a significant result at the adapted level, using the Bonferroni method.

Further comparisons were then made between the separate groups (Table 1). Patients with DDNOS and MPD did not differ among each other in the severity of any of the symptoms. Both did differ significantly from group IV (cluster B control) in the severity of each of the dissociative symptoms. Both groups also differed significantly from group III (cluster B consult) in the severity of amnesia, identity confusion, and identity alteration. The depersonalization and derealization symptoms, however, did not differ significantly between patients with DDNOS or MPD and patients from group III.

The two groups of patients with a cluster B personality disorder (groups III and IV) also differed between each other in the severity of each of the dissociative symptoms. Patients in group III suffered from more severe dissociative symptoms than did patients in group IV (Table 1). A graphic representation of the differences in severity of the five dissociative symptoms is presented in Figure 1.

Further Comparison of Prevalence of Separate Dissociative Symptoms

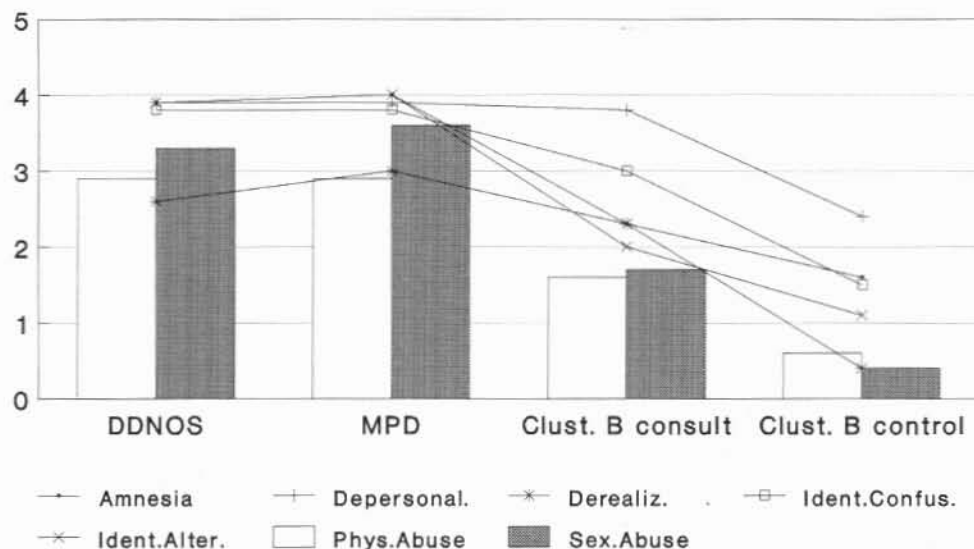
A further analysis was conducted of the prevalence of the separate dissociative symptoms in the four groups.

Amnesia: The groups differed significantly among each other in prevalence of amnesic episodes ($\chi^2=56.66$; $df=3$; $p<.0001$). Further comparisons between groups showed that

almost all patients with DDNOS or MPD reported persistent episodes of amnesia, daily or weekly episodes; specific blocks of time that could not be accounted for; or, fugue states (finding oneself in unfamiliar surroundings).

Although a majority of patients in group III (81.0%) mentioned some form of amnesia, this was in a mild form. Moreover, the description of amnesia differed qualitatively from the description of patients with MPD or DDNOS. Patients in group III reported occasional memory difficulties, closely linked with the experience of depersonalization in the present, or some form of amnesia for childhood experiences. Very few patients in this group reported fugue states, or specific blocks of time miss-

FIGURE 1
Dissociation and severity of trauma in four diagnostic groups



Instruments: SCID-D & STI

Severity range: 1-4 (dissoc. symptoms), 0-3 (phys. abuse), 0-4 (sex. abuse)

TABLE 1
Severity of dissociative symptoms in four different diagnostic groups (means, standard deviation) and overall comparison
by analysis of variance (df=3, 109)

DISSOCIATIVE SYMPTOMS	I		II		III		IV		F	p<
	DDNOS*		MPD		Cluster B		Cluster B			
	(N=24)		(N=49)		(N=21)		(N=19)			
	M	SD	M	SD	M	SD	M	SD		
Amnesia	3.9	0.3.	4.0	0.1	2.3	1.0	1.6	1.0	92.72	<.0001
Depersonalization	3.9	0.3	3.9	0.3	3.8	0.4	2.4	1.1	12.22	<.0001
Derealization	2.6	1.6	3.0	1.3	2.3	1.1	0.4	1.0	18.17	<.0001
Identity Confusion	3.8	0.7	3.8	0.6	3.0	1.0	1.5	0.8	50.37	<.0001
Identity Fragmentation	3.9	0.3	4.0	0.0	2.0	1.2	1.1	0.5	52.21	<.0001
Total SCID-D Score	18.2	1.9	18.9	1.4	13.6	3.4	8.0	2.4	135.48	<.0001

Applying Bonferroni method, the adapted level of alpha is: $\alpha = .05 / 6 = .008$

Significance of differences in severity between the four separate diagnostic groups:

		Dissociative Symptoms (SCID-D)				
		Amnesia	Depers.	Dereal.	Ident. Conf.	Ident. Frag.
I	II	NS	NS	NS	NS	NS
I	III	<.0001	NS	NS	<.01	<.0001
I	IV	<.0001	<.0001	<.001	<.0001	<.0001
II	III	<.0001	NS	NS	<.001	<.0001
II	IV	<.0001	<.0001	<.0001	<.0001	<.0001
III	IV	<.05	<.0001	<.01	<.0001	<.0001

Severity Ratings: 1 (Absent), 2 (Mild), 3 (Moderate), 4 (Severe)

ing. Dissociative disorder patients differed significantly from patients in group III in the prevalence and severity of clear blocks of time missing and the occurrence of fugue states.

Only a minority of the patients in group IV (26.3%) reported some memory difficulties. There was no qualitative difference in the description of amnesia between groups III and IV. Memory problems in group IV were associated also with episodes of depersonalization, or sometimes with childhood experiences. Patients in group III, however, differed significantly from patients in group IV in the prevalence and severity of some amnesia items.

Depersonalization: General feelings of estrangement or detachment were present in a majority of patients in all groups. Other experiences — such as watching oneself from a point outside the body, altered perception of the body ($\chi^2=67.60$; $df=3$; $p<.0001$), or being analgesic to pain ($\chi^2=59.48$; $df=3$; $p<.0001$) — were very prevalent among patients with a dissociative disorder (93.5–93.9%) and frequently reported by patients in group III (46.6% and 70.0% respectively), but almost absent in group IV (5.3%). There was considerable overlap in the quality of the depersonalization experiences between groups I, II, and III. The description of depersonalization by patients in group IV differed, however, from the other three groups. Patients in group IV gave vaguer descriptions of depersonalization, such as feeling unreal, or behaving like an automaton. These feelings were associated primarily with stress, panic attacks, or chaotic behavior. The two personality disorder groups differed significantly among each other on each of the depersonalization items, group III reporting the more frequent and severe episodes of depersonalization.

Derealization: General feelings of derealization, such as the feeling that one's surroundings become vague ($\chi^2=24.27$; $df=3$; $p<.0001$) or unreal ($\chi^2=24.66$; $df=3$; $p<.0001$), were prevalent in groups I, II, and III, but not in group IV. Only a minority of the patients in group IV reported such feelings. One item, "not recognizing one's friends or relatives," clearly differentiated patients with a dissociative disorder from the two groups of patients with a personality disorder. This item refers to a more severe dissociative state, in which the person apparently does not react to close friends, or does not recognize them. This experience was reported by a majority of patients with a dissociative disorder, but only 10% of the patients in group III. It was absent in group IV. Finally, patients with a dissociative disorder experienced feelings of derealization more frequently than did patients with a personality disorder. Again, group III reported significantly more derealization than did group IV.

Identity Confusion: The majority of patients in all four groups reported an ongoing internal struggle. However, patients with a dissociative disorder differed strongly from patients with a personality disorder (both groups III and IV) regarding the quality of the internal struggle that they described. Of the patients with a dissociative disorder, 95.8% described an ongoing struggle between several (more than two) parts inside themselves. Often they could hear these parts as different voices. Patients with a personality disorder described a polarized struggle between two ideas, or thoughts, or parts inside (90–100%). Subjective feelings of confusion

about one's self or one's identity were very prevalent among patients with a dissociative disorder. They also were reported frequently by patients in group III, but only by one-third of the patients in group IV.

Identity Alteration: Patients with a dissociative disorder differed significantly on all items from patients with a personality disorder, although a majority of the patients in group III reported they sometimes behaved as if they were a different person. With follow-up questions they could be distinguished from patients with a dissociative disorder. Most patients with a personality disorder (groups III and IV) experienced these different behaviors as ego-syntonic and, once again, often described very polarized behavior as opposed to patients with a dissociative disorder. Patients with a dissociative disorder described the different behaviors as ego-dystonic. Moreover, the question about their behavior as a different person typically evoked answers in dissociative disorder patients about having specific capacities that they were unaware of, or displaying a certain behavior for which they had amnesia. Of the two groups of patients with a personality disorder, group IV was negative for almost all items of identity alteration.

Of interest is a comparison of the reactions — verbal and non-verbal — of the different groups to questions on identity alteration. In general, the patients with DDNOS had the most difficulty in answering questions during this part of the interview. They became vague, started to dissociate, had amnesia for the questions of the interviewer, or reported an increase in activity of voices in their head. Sometimes they would say that a voice in their head told them not to answer any questions, or that their thoughts were withdrawn, or their "mind went blank."

The majority of MPD patients did not display these problems. Questions on identity alteration evoked answers about their alter personalities. In the discussion paragraph we give hypotheses for these different reactions between the two groups of patients with a dissociative disorder.

Patients with a personality disorder (groups III and IV) showed no difficulty in answering questions on identity alteration. Either they did not recognize the experiences, or gave examples that were qualitatively quite different from those of patients with a dissociative disorder. They never dissociated or reported hearing voices that interfered during the interview.

Comparison of Prevalence of Some Schneiderian and Other Psychotic Symptoms

Patients with dissociative disorders differed significantly from patients with personality disorders in the prevalence of some Schneiderian symptoms and some other psychotic symptoms. Schneiderian symptoms such as voices in one's head ($\chi^2=39.97$; $df=3$; $p<.0001$), voices commenting ($\chi^2=59.56$; $df=3$; $p<.0001$), or passive influence phenomena ($\chi^2=50.87$; $df=3$; $p<.0001$) were very prevalent among patients with a dissociative disorder. Ongoing internal dialogues were very prevalent among patients with a dissociative disorder, but also common among patients with a personality disorder. Once again, the quality of these dialogues differed. Patients with a personality disorder (both groups

III and IV) described these dialogues as similar to their own — often very polarized — thoughts; patients with a dissociative disorder described these dialogues as conversations between different voices in their heads, or a variety of opinions or thoughts. These thoughts, opinions, or voices were experienced as not being their own thoughts, or as ego-dystonic.

Suicidality, Self-mutilation, Symptoms of Eating Disorder

We investigated suicidality, self-mutilation, and symptoms of eating disorder. Although suicidality was present in all four groups, recurrent suicide attempts were much more prevalent in groups I, II, and III.

The four groups differed significantly among each other in self-injurious behavior, such as cutting and burning, or inflicting wounds ($\chi^2=22.91$; $df=3$; $p<.0001$). The prevalence of self-mutilation was high among patients with a dissociative disorder: 78.3% of the patients with DDNOS and 83.3% of the patients with MPD reported recurrent self-injury, although often they were amnesic for this behavior. Self-mutilation was also common in group III (76.2%) but much less prevalent in group IV (26.3%).

Recurrent suicide attempts were reported by all four groups: In group I by 45% of the patients; in group II by 55%; in group III by 52%; and in group IV by 26% of the patients.

The four groups did not differ in the prevalence of symptoms of eating disorders. However, 52% of the patients with DDNOS and 53% of the MPD group reported amnesia associated with binge-eating. This was not mentioned by patients with a personality disorder.

PTSD and BPD

Post-traumatic symptoms were very prevalent in groups I, II, and III, and almost absent in group IV. Overall group differences in the number of criteria met were significant: re-experience of trauma ($F=37.25$; $df=3.92$; $p<.0001$), avoidance of stimuli associated with trauma ($F=28.86$; $df=3.91$; $p<.0001$), and increased arousal ($F=47.26$; $df=3.92$; $p<.0001$). Full assessment of post-traumatic stress disorder in the patients with a dissociative disorder was not always possible, because some of the patients reported amnesia for their childhood, or were unable to report traumatic experiences. In spite of this limitation, we found that the four groups differed significantly in the occurrence of PTSD ($\chi^2=27.5$; $df=3$; $p<.0001$). Sixty percent of patients with DDNOS and 89% of patients with MPD met full criteria for PTSD. In all other patients with a dissociative disorder, full assessment of PTSD was not possible due to amnesia. Of the patients with a personality disorder, 65% of group III and 11% of group IV met criteria for PTSD.

Although there were significant overall group differences in the number of patients meeting *DSM-III-R* criteria for borderline personality disorder, assessed in the research interview ($\chi^2=16.68$; $df=3$; $p<.0001$), groups I, II, and IV did not differ (41%, 40%, and 42%, respectively). In group III (cluster B consult), 90% of the patients met criteria for BPD. The mean number of borderline criteria did not differ between

the dissociative disorder patients (DDNOS met 4.0 criteria; MPD met 4.4) and the patients of group IV (3.4), but they differed significantly from group III (6.0 BPD criteria) ($F=8.84$; $df=3.103$; $p<.0001$).

Comparison of Prevalence and Severity of Child Abuse

Although we found overall significant differences in the prevalence of physical ($\chi^2=26.45$; $df=3$; $p<.0001$) and sexual abuse ($\chi^2=15.29$; $df=3$; $p<.0001$) among the four diagnostic groups, the dissociative disorder patients (77.6 - 91.0%) did not differ significantly from group III, the "cluster B consult" group (57.1 - 61.0%). And the two groups of personality disorder patients did differ among themselves in the prevalence of both physical and sexual abuse.

However, patients with a dissociative disorder differed significantly from patients in groups III and IV in the severity of physical and sexual abuse; patients in group III reported significantly more severe sexual and physical abuse than did patients in group IV (Table 2).

Patients with a dissociative disorder, almost all reporting having been abused under the age of six, differed significantly from patients with a personality disorder in age of onset of sexual abuse ($F=28.68$; $df=3.56$; $p<.0001$); patients in Group III ("cluster B consult") reported sexual abuse at an earlier age (between six and twelve) than did the control patients in group IV (abused, in most cases, in early adolescence).

Figure 1 shows a graphic representation of the differences in severity of child physical and sexual abuse and the five dissociative symptoms.

DISCUSSION

We have compared these four groups to look for similarities and differences among patients with a dissociative disorder and patients with a cluster B personality disorder. Also, we were interested in investigating whether we could find differences between the two groups of patients with a dissociative disorder and the two groups of patients with a cluster B personality disorder. Too often these four groups are not differentiated at all in clinical practice in the Netherlands. They are classified and treated as cluster B or the "dramatic cluster."

MPD and DDNOS

Patients with MPD or DDNOS did not differ significantly in severity of dissociative symptoms or in total SCID-D score. Neither did they differ in any of the other symptoms nor in PTSD symptoms, BPD symptoms, or trauma histories. Since follow-up data showed the majority of the patients who met criteria for DDNOS during the research interview later met criteria for MPD, it is not surprising that we did not find major differences between the two groups. However, we did find some difference in two areas: (1) their verbal and non-verbal reactions toward specific parts of the interview; and (2) their awareness of the existence of alter personalities.

A majority of patients presenting with a DDNOS profile reacted more strongly to questions about amnesia, identity

TABLE 2
Severity of childhood physical and sexual abuse in four different diagnostic groups (means, standard deviation) and overall comparison by analysis of variance (df=3, 86)

TYPE OF ABUSE	I		II		III		IV		F	p<
	DDNOS*		MPD		Cluster B		Cluster B			
	(N=24)		(N=49)		(N=21)		(N=19)			
	M	SD	M	SD	M	SD	M	SD		
Child physical abuse	2.9	0.2	2.9	0.4	1.6	1.3	0.6	0.9	47.58	<.00001
Child sexual abuse	3.3	0.5	3.6	0.6	1.7	1.3	0.4	0.9	46.55	<.00001

Applying Bonferroni method, the adapted level of alpha is: $\alpha = .05 / 2 = .0025$

Significance of differences in severity of abuse among the four separate diagnostic groups:

Differences between:		Type of Abuse	
		Physical Abuse	Sexual Abuse
I	II	NS	NS
I	III	.0001	.0001
I	IV	.0001	.0001
II	III	.0001	.0001
II	IV	.0001	.0001
II	IV	.01	.01

Severity Ratings: 1 (Absent), 2 (Mild), 3 (Moderate), 4 (Severe)

alteration, and Schneiderian symptoms than did the MPD patients, who seemed to be more at ease when talking about their symptoms. During these parts of the interview, patients with DDNOS often became defensive, started to dissociate, or reported interference from voices in their head. They displayed more ambivalence and internal struggle than did the patients who were already in treatment for MPD.

The patients with DDNOS gave many direct or indirect indicators (or "muted signs") for the presence of alter personalities, such as having been told by others of behaviors they had forgotten, or the discovery of possessions they could not account for. However, not one of the patients with DDNOS was able to give an explanation for these experiences, or to talk about alter personalities.

These findings confirm strongly the clinical observations that the majority of MPD patients initially minimize, deny, or are unaware of their dissociative symptoms (Kluft, 1985; 1987b&c; Putnam et al., 1986; Franklin, 1990).

Compared to Horevitz and Braun (1984), we did not find as many MPD (or DDNOS) patients meeting DSM-III-R borderline criteria (70% versus 40% - 41%).

The Cluster B Personality Disorders

The patients of groups III and IV had clinical diagnoses of a cluster B personality disorder. However, almost all the patients in group III met criteria for BPD (19 or 21), whereas only eight of the nineteen patients in group IV met criteria for BPD. Likewise, the mean number of BPD criteria met in those groups differed. Moreover, we observed a trend that patients of group III had entered treatment at an earlier age (mean = 19.8) than did patients of group IV (mean = 25.4) ($t=1.92$; $df=36$; $p<.10$). This is a limitation for a strict comparison of these groups. Since there is a tendency in clinical practice to conceptualize patients with a cluster B personality disorder as rather homogenous — albeit with great overlap in symptoms — we decided to take a closer look at both groups.

The group of patients who were referred by their treating therapist for evaluation of dissociative symptoms, had the highest concentration of borderline characteristics. The cluster B control patients were similar to the dissociative patients in this respect.

We found patients of group III (cluster B consult) differed significantly from patients of group IV (cluster B control) on the prevalence and severity of dissociative symptoms, in particular depersonalization, the prevalence of PTSD, and self-injurious behavior. And finally, these two groups could be differentiated in prevalence and severity of a history of childhood sexual and physical abuse. Patients in group III reported a high prevalence of childhood sexual and physical abuse, whereas the majority of patients in group IV — including the subgroup of eight BPD patients — reported histories of emotional neglect only. These findings support an association between traumatic experiences, dissociative pathology, and self-injurious behavior. They are consistent with several other studies (Herman, Perry, & van der Kolk, 1989; Fink & Golinkoff, 1990; Coons & Milstein, 1990; van der Kolk, Perry, & Herman, 1991).

A comparison between these two groups shows that patients with rather different symptom profiles are being subsumed within the same diagnostic categories on Axis II. In our study we have found that borderlines with a history of childhood physical and sexual abuse endorse many more dissociative symptoms, particularly severe and chronic depersonalization, compared to borderlines who have experienced emotional neglect only. In our opinion, this would justify an Axis I diagnosis of depersonalization disorder in those cases. Such a diagnosis would be meaningful (in addition to the Axis II diagnosis) because the depersonalization seems to be related to traumatic childhood experiences that need to be taken into account.

DDNOS and "Cluster B Consult"

Finally, we compared the patients with DDNOS (group I) with the patients referred to us for an evaluation of a dissociative disorder (group III or "cluster B consult"). This last comparison is very relevant for clinical practice, in our opinion, because drawing a distinction between these two groups is the most difficult. It concerns the distinction between MPD patients (four out of ten with co-existing BPD diagnoses), who present with subtle signs of MPD but do not meet full criteria for the condition, and physically or sexually abused patients with BPD or histrionic personality disorder. In clinical practice these two groups of patients are the most difficult to differentiate, because they both endorse many dissociative symptoms. In addition, most MPD patients initially do not present as MPD. As we have found, often they are unaware of the presence of alter personalities. A comparison between the scores of the two groups generated by the SCID-D has shown both groups reported severe and chronic depersonalization. Yet, patients with DDNOS could be differentiated clearly from patients of group III on almost all the items about amnesia, identity confusion, and identity alteration. The two groups could be differentiated also by the prevalence of Schneiderian symptoms. Patients with DDNOS endorsed more first-rank symptoms. Lastly, the two groups also differed distinctly in the severity of childhood physical and sexual abuse and the age at which it had begun.

A comparison between the patients' reactions to the SCID-D interview is clinically relevant. As we described, most of the patients with DDNOS had difficulties answering certain sections of the SCID-D interview, in particular questions directly or indirectly referring to the presence of alter personalities (such as time loss, hearing of voices, finding objects that cannot be accounted for, etc.). By contrast, the patients in group III did not seem to encounter these problems. They did not react defensively, nor start to dissociate, and were often willing to give all kinds of examples of amnesia, because amnesia in the present was not a real problem for them. They had no alter personalities to conceal. Their examples were qualitatively very different from the examples of time loss of DDNOS patients. In addition, there were no voices interfering during the interview, in contradistinction to the patients with DDNOS who often reported constant interference of voices during the course of the interview.

In summary, there is a cluster of dissociative symptoms

in present time, including different reactions towards the SCID-D interview, differentiating patients with "covert" MPD from patients with a cluster B personality disorder and a trauma history. Moreover, these patients can be differentiated by the severity and age of onset of childhood physical and sexual abuse. It is of importance to emphasize, however, that in some of these very complicated cases there is no "definitive answer" about the possibility, or probability, of MPD after the SCID-D interview. Some patients manage to sit through a two-hour interview without dissociating, and they deny and are unaware of amnesic episodes, or indicators for identity alteration. Although we did not gather systematic follow-up data on all the patients in group III, we do have information from their treating clinicians on eighteen of the twenty-one patients. There were no indications for the presence of MPD during the course of the treatment, except for one patient whose dissociative disorder went undetected at the research interview. This concerned a young adolescent who successfully confused the interviewer, denied most dissociative symptoms, and displayed many "borderline" defenses during the interview. Her whole presentation was vague and rather mystifying. Moreover, at the time of the interview, the patient was participating in a treatment program with other traumatized adolescents and there was uncertainty as to whether she was mimicking the behavior of other patients. After the interview, it gradually became more apparent that there were episodes of considerable time loss. About half a year later, alter personalities presented themselves in her individual therapy.

CONCLUSIONS

The following tentative conclusions can be drawn from this study:

- 1) Although there are many areas of overlap in the phenomenology of patients with MPD or DDNOS and patients with a "cluster B" personality disorder, we clearly found that these groups can be differentiated by the severity and cluster of dissociative symptoms, the prevalence of some Schneiderian symptoms, and the severity of childhood trauma.
- 2) In this study, MPD and DDNOS patients differed mainly in their awareness of the presence of alter personalities and their defensive reactions during difficult parts of the SCID-D interview. More studies are needed to determine how frequently, as in our study, DDNOS is a presentation of MPD.
- 3) Patients with a cluster B personality disorder, in particular BPD, may have very heterogeneous symptom profiles. Patients with recurrent suicidality, self-mutilation, or a history of childhood trauma should be routinely screened for the presence of dissociative pathology.
- 4) An Axis I diagnosis of depersonalization disorder is

meaningful in Axis II personality disorder cases with a history of childhood physical or sexual abuse. Chronic and severe depersonalization seems to be related primarily to the trauma history and is not just a "symptom of a personality disorder."

- 5) Clinicians should become more aware that MPD does not present as MPD. A typical "dramatic" BPD presentation may actually represent a case of MPD.
- 6) The diagnostic process of MPD can go through several stages. At the first diagnostic evaluation with the SCID-D, a majority of patients will meet criteria for DDNOS, or possibly depersonalization disorder. Gradually, more information may become available on alter personalities and the diagnosis of MPD can be confirmed. In some cases a prolonged diagnostic phase is necessary because the condition is very well concealed. ■

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