THE DIFFERENTIAL DIAGNOSIS OF MULTIPLE PERSONALITY DISORDER FROM BORDERLINE PERSONALITY DISORDER

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ABSTRACT

Considerable controvery surrounds the relationship between multiple personality disorder (MPD) and borderline personality disorder (BPD). Some authors argue that MPD is a variant of BPD, and most agree that the differential diagnosis of the two is often very difficult. In this article data are presented from a study comparing historical, demographic and psychological testing variables between the two groups. No statistically significant differences were found between the two groups on these variables. However, certain trends emerged which may serve as a catalyst for further research. The relationship between the disorders may be complex; clinicians may need to use more sophisticated research techniques and develop more sensitive diagnostic criteria before it is understood.

A common theme presented in the literature on multiple personality disorder (MPD) has been the lack of consensus on the prevalence of the disorder (Boor, 1982; Coons, 1984: Gruenewald, 1977; Horevitz & Braun, 1984). Historically, the popularity of MPD as a diagnosis has fluctuated. The disorder first gained prominence as a diagnosis during the late nineteenth and early twentieth centuries, at which time it was linked closely to hysteria, and often discovered by and treated with hypnosis. In the middle years of this century, the frequency of the MPD diagnosis declined along with the use of hypnosis; the belief that hypnosis induced multiple personality became widespread. Several investigators have reported that MPDs were frequently misdiagnosed as schizophrenics during the period (Boor, 1982; Coons, 1984; Horevitz & Braun, 1984).

The reported incidence of MPD has increased sharply in recent years, to what some believe are epidemic proportions. Boor has noted that it is unclear whether there is a genuine increase in incidence or merely a change in "diagnostic inclinations" (Boor, 1982, p.302). Despite this increase, some experts are of the opinion that the disorder continues to be overlooked or misdiagnosed too frequently (Coons, 1984; Putnam, Guroff, Silberman, Barban & Post, 1986). In their review of 100 cases of multiple personality, Putnam, et al. (1986) found that 95 percent of their subjects had been given other psychiatric and/or neurological diagnoses prior to their receiving the "correct" MPD diagnosis.

Although our knowledge of the etiology and symptomatology of MPD has increased substantially along with the increase in reported incidence, the differential diagnosis of the disorder from related emotional disorders remains difficult (Coons, 1984; Gruenewald, 1988; Stern, 1984; Kluft, 1987). In current literature MPD has been linked with a variety of other diagnoses, including several of the personality disorders (Gruenewald, 1977; Stern, 1984; Clary, Burstin & Carpenter, 1984), major affective disorders (Gruenewald, 1977; Horevitz, 1984; Putnam, et al., 1986), and schizophrenia (Boor, 1982; Bliss, 1984).

Often MPD is seen as having characteristics in common with borderline personality disorder (BPD) to the extent that it is quite difficult for the diagnostician to differentiate between these disorders. In addition to DSM III criteria, there are other symptoms of multiple personality frequently reported in the literature which correspond to the diagnostic criteria for borderline personality disorder, including identity disturbance, affective instability, and a propensity for self-damaging acts. Feelings of despression, anxiety and depersonalization are routinely reported with both disorders.

A major unresolved issue presented in the literature is whether or not MPD is a separate and distinct condition or represents a variation of BPD. In a theoretical analysis of the two disorders, Clary et al. pointed to the commonalities between the two disorders and concluded that "the multiple personality represents a 'special instance' of borderline personality disorder" (Clary et al., 1984, p.98). Horevitz and Braun (1984) on the other hand, found MPD to be a "separate and distinct syndrome" (Horevitz & Braun, 1984, p. 83) even though 70 percent of their research sample of 33 MPD patients met DSM III criteria for borderline personality disorder. They concluded that the overall level of dysfunction of patients with the dual diagnosis of MPD and BPD was greater than that of MPDs with a more stable history. A study conducted by Schultz, Kluft, and Braun (1986) identified

the identical percentage of MPD subjects, 70 percent, as meeting the clinical criteria for a dual diagnosis of MPD and BPD.

The purpose of the present study was to identify diagnostic variables which might distinguish between individuals with multiple personality disorder and those with borderline personality disorder, in an attempt to aid clinicians in differential diagnosis. Unlike earlier studies (Horevitz & Braun, 1984; Schultz, Kluft, & Braun, 1986), a subject-report measure and psychological tests were used in addition to clinician report. It was our hope that this would provide more accurate data.

The following variables were examined:

1) scores on standard psychological tests of cognitive and personality functioning (the MMPI and the Shipley Institute of Living Scale);
2) psychosocial history in the areas of education, employment, marriage, emotional and/or physical abuse, previous diagnoses and hospitalizations for mental illness, age of onset of mental disorder, suicide attempts, eating disorders, sleeping disorders, and substance abuse;
3) clinician report of presenting symptomatology of the patient (Brief Psychiatric Rating Scale); and
4) the severity of psychosocial stressors and the highest level of adaptive functioning over the past year (the Axis IV and Axis V diagnoses of treating clinician).

Eight of the MPD patients had been diagnosed by a psychiatrist and two psychologists who had experience diagnosing the disorder. Two MPD patients were diagnosed by clinical social workers whose previous diagnostic experience with MPD is unknown. Diagnosis for the ten BPD subjects had been made by three psychologists and a psychiatrist, all of whom have had diagnostic experience with BPD patients. In the majority of cases, the diagnosis had been confirmed by other clinicians.

METHOD

Each subject was selected on the basis of his/her DSM III diagnosis. Subjects included 10 individuals in Group I carrying an MPD diagnosis on Axis I, but no BPD diagnosis on Axis II, and, in Group 2, 10 subjects carrying a BPD diagnosis on Axis II. but no MPD diagnosis. Subjects were receiving mental health treatment at either a local medical center or a local mental health center, or were under the care of a private practitioner. Clinicians who were treating the patients included psychologists, psychiatrists, clinical social workers and a psychiatric nurse practitioner. Readers not familiar with the use of the Shipley Institute of Living Scale as a measure of intellectual ability are referred to Winkler (1981) for a review. Those not familiar with the Brief Psychiatric Rating Scale can find a consise review in *The Handbook of Psychiatric Rating Scales* (NIMH, 1973). Subjects' participation was solicited through personal contacts with the treating clinicians. Data were collected between August, 1986 and October, 1987.

The statistical design of the study included analysis of variance for continuous variables such as MMPI sub-scale scores and estimated IQs. The Chi-square statistic was used to test for significant differences among categorical vari-

TABLE 1
Means, ranges, standard deviations and T scores of
10 MPD patients and 10 BPD patients on the MMPI

	MPD				BPD			
	MEAN	RANGE	SD	T SCORE	MEAN	RANGE	SD	T SCORE
L	5	1-11	1.86	53	2.7	0- 8	2.40	45
F	17.7	8-32	7.15	83	17.7	9-38	8.71	83
K	12.5	5-22	5.44	50	10.7	4-18	5.33	47
1	32	17-31	5.27	89	28.8	14-34	6.82	83
2	35.3	30-40	2.63	80	36.9	28-47	7.99	83
3	34.7	26-39	5.52	79	33.1	27-49	7.51	75
4	33.4	28-41	4.24	83	33.7	24-39	4.27	84
5	37	19-48	8.07	49	35.3	26-42	5.40	53
6	17.6	11-23	3.70	79	18.9	14-28	4.93	80
7	44.4	36-55	5.42	82	42.9	34-56	7.72	79
8	48.4	32-71	12.50	89	48.5	31-58	8.78	90
9	21.8	17-27	3.36	2	21.7	8-33	6.93	62
0	43.7	31-53	6.68	71	43.1	34-57	9.49	69

ables. A procedure recommended by Newman and Frye (1983) was used to correct for multiple comparisons.

RESULTS

An analysis of MMPI data revealed no significant differences between mean scale scores of MPD patients and BPD patients. These data are presented in Table 1. Although ranges presented on the individual scale scores are fairly wide, this variability, as measured by standard deviation, is minimal. Mean MMPI profiles for the two groups are quite similar and indicative of severe psychopathology, with most scales elevated above a T score of 70. For both groups, the highest scale was Scale 8, followed by 1, 4 and 7 for the MPD group, and 4, 1, and 2 for the BPD group. The F Scale was significantly elevated for both groups, with a mean T score of 83. Patients in both groups apparently endorsed items in a manner similar to individuals who are either responding randomly, consciously exaggerating symptoms, or endorsing symptoms indicative of severe maladjustment and diverse symptomotology.

Mean scores for the two groups on the Shipley Institute of Living Scale, 110 for MPD subjects and 103 for BPD subjects, were not significantly different (Table 2). However, range of scores was notably larger for the BPD group (67 - 114) than for the MPD group (100 - 116).

Comparison of demographic data showed no significant differences between groups (Table 3), although two trends are evident. Forty percent of the MPD patients had earned degrees beyond high school, whereas none of the borderline patients had done so. Of the MPD group, 20 percent were on welfare at the time of the study, in contrast to 60 percent of the BPD group.

Similarly, data on psychosocial history, reported in Table 4 show no significant differences, but are suggestive of certain trends. A history of sexual abuse in the home was reported by 60 percent of the MPD subjects, but only 20 percent of those with BPD. Sixty percent of the BPD's reported a police record, whereas only 10 percent of the MPD's did so. The largest reported difference was on a question asking about a past history of amnesia; 80 percent of the multiple personality patients reported experiencing such episodes, while none of the borderline patients did so.

The presenting symptomology of the two groups of patients, as measured by clinician report on the Brief Psychiatric Rating Scale, also showed no statistically significant differences between group mean scores (Table 5). The degree of variability within groups was notable, however.

Responses to the clinician questionnaire, reported in Table 6, showed a marked degree of pathology for both groups, and, once again, no differences between groups. Reportedly, 60 percent of the MPD subjects and 70 percent of the BPD subjects have attempted suicide at least once, many several times. Seventy percent of the MPDs were reported to have an eating disorder and/or a sleep disorder, whereas 40 percent of the BPD patients were reported to be suffering from these disorders. Sixty percent of both groups were judged to have problems with substance abuse. Psychosexual problems were reportedly experienced by 70

TABLE 2
Scores on the Shipley Institute of Living Scale for 10 MPD's and 10 BPD's

MPD	BPD
112	102
104	67
100	109
116	114
110	95
115	103
109	114
106	113
112	112
116	Not available
Average: 110	Average: 103

TABLE 3
Comparison of 10 MPDs and 10 BPDs on Demographic Data

	MPD	BPD
Age	36.6	37.1
Sex	80% Female	70% Female
Religion Important	50%	20%
Years of Schooling	14.2	12.3
Highest Degree Earned:		
None	0%	20%
High school	60%	70%
GED	0%	10%
B.A.	20%	0%
M.A.	10%	0%
L.P.N.	10%	0%
Marital Status:		
Single	30%	50%
Married	30%	30%
Divorced	40%	20%
No. of Children	1.5	.9
Employed	60%	30%
On Welfare	20%	60%
No. of Jobs in past 10 yrs	2.8	4.1

percent of the MPD patients and 30 percent of the BPD patients. Similarities between groups are evident on the clinicians Axis IV and Axis V diagnoses.

DISCUSSION

On the basis of data collected in this study, patients diagnosed as multiple personality disorder and those diagnosed with borderline personality disorder look remarkably similar. The MMPI does not appear to differentiate between the two disorders. In fact, both groups tend to respond in a manner that suggests psychological distress so severe it brings the validity of their responses into question. This picture is consistent with what has been reported in literature on borderline personality disorder (Gartner, 1987), as well as studies examining MMPI profiles of multiple personalities (Bliss, 1984; Wagner & Wagner, 1986; Gilbertson, Torem, & Kemp, 1988). Analysis of demographic and symptomatic data provided no concrete evidence that overall level of dysfunction for BPDs is greater than it is for MPDs.

Despite the apparent close similarities between the two disorders, however, certain trends are suggested which may be helpful to the diagnostician and appear to merit further examination. MPD patients may present a somewhat more stable history than BPD patients, including more years of education and fewer changes of employment. Encounters with the legal system may be less common for MPDs. Sexual abuse, particularly within the family, seems more likely to be reported by multiple personality patients. Although intellectual level alone does not appear to differentiate the two groups, this study supports findings of other researchers who have argued that below average intellectual functioning may be used in conjunction with other empirical data to contraindicate an MPD diagnosis (Wagner & Wagner, 1986). It is possible that a key difference between the two groups is the acknowledgment of a memory disturbance; in light of the DSM III guidelines, this is most likely the basis upon which clinicians made the MPD diagnosis in the first place.

TABLE 4
Comparison of 10 MPDs and 10 BPDs on social history

	MPD	BPD
Harsh physical punishment in home	70%	60%
Sexually abused in home	60%	20%
Sexually abused outside home	50%	30%
Violent crime victim	60%	70%
School suspensions/ expulsions	20%	50%
School truancy/ absenteeism	30%	50%
Arrest record	10%	60%
Age/first mental health treatment	27.5%	22.1%
No. of mental health providers	3.6%	4.9%
Amnesic episodes	80%	0%
Alcohol use	50%	50%
N-P drug use	20%	40%
Substance abuse treatment	20%	50%
Substance abuse problems	20%	20%
Suicide attempts	50%	70%

TABLE 5
Clinician Report of Presenting Symptomatologyof MPDs and 10 BPDs on the Brief Psychiatric Rating Scale

	MPD	BPD
Somatic concern	2.9	2.7
Anxiety	3.9	3.8
Emotional WD	1.2	2.1
Conceptual Disorganization	.4	1.2
Guilt Feelings	3.4	3.0
Tension	3.2	2.8
Mannerisms and Posturing	.7	1.0
Grandiosity	.7	1.6
Depressive Mood	3.4	3.5
Hostility	1.5	2.4
Suspiciousnes	1.7	1.6
Hallucinatory Behavior	1.0	.2
Motor Retardation	1.1	1.2
Uncooperativeness	1.0	.7
Unusual Thought Content	.8	1.5
Blunted Affect	1.4	.8

0 = Not present *1 = Very mild* *2 = Mild*
3 = Moderate *4 = Moderate severe*
5 = Severe *6 = Very severe*

TABLE 6
Comparison of Clinicians' Reports in 10 MPD Patients and 10 BPD patients including Axiss IV and Axis V Diagnosis

	MPD	BPD
No. of hospitalizations	80%	80%
Age at first hospitalization	28.5	26.75
Suicide attempts	60%	70%
Eating disorder	70%	40%
Sleep disorder	70%	40%
Substance use disorder	60%	60%
Psychosexual disorder	70%	50%
Axis IV*		
Mild	10%	10%
Moderate	10%	30%
Severe	30%	30%
Extreme	20%	0%
Axis V*		
Fair	30%	10%
Poor	30%	40%
Seriously impaired	10%	30%

* *Totals do not equal 100% due to clinician non-reporting in some instances.*

Limitations of this study should be taken into consideration when examining the results. The small N size and resulting lack of power make the likelihood of a Type II error high. In other words, restricted sample size may have precluded finding a significant difference between groups that does exist. Also, results cannot be generalized to a broader population due to the small sample size; rather, they should be considered a tentative beginning in this area of research. The investigation was clearly handicapped by limited number of available MPD subjects. If the reported incidence of the disorder continues to increase, differentiating characteristics may become easier to statistically ascertain. In addition, any diagnostic inaccuracy would, of course, cast doubt on the validity of the study. It was assumed that each subject carried an accurate diagnosis.

By design, multiple personality disorder and borderline personality disorder were examined as separate and distinct disorders in this study. Overlapping of characteristics between the two was substantial enough, however, to be considered consistent with the research of Horevitz and Braun (1984) and Schultz, et al. (1986) in which 70 percent of the MPDs studied were found to present a clinical picture sufficient for a BPD diagnosis as well. It seems likely that in many instances the two disorders are not independent of one another.

Clinicians may need to expand their repertoire of measurement tools and techniques before a clearer differential picture of these disorders emerges, if one exists. The relationship between the two diagnostic categories may be more complex than we have suspected and its analysis most likely will require more sophisticated research and statistical techniques. Also, as we become more knowledgeable of the symptomatic picture presented by patients with mutiple personality disorder, an expansion of the development and the course of this disorder is clearly in its infancy. ■

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