IATROGENIC FACTORS IN THE MISDIAGNOSIS OF MULTIPLE PERSONALITY DISORDER

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ABSTRACT

The diagnosis of multiple personality disorder (MPD) is fraught with difficulties leading to a frequent false negative diagnosis and an occassional false positive diagnosis. Proper diagnostic evaluation of a patient suspected of having MPD requires a familiarity with MPD, hypnotic phenomena, and a wide variety of other clinical syndromes. The clinician must use collateral data from old records and other individuals as well as provide sufficient time for the evaluation. Extreme caution is urged in forensic contexts. The use of extremely suggestive interviewing and/or hypnotic techniques is to be deplored. At times prolonged observation in the hospital or over the course of therapy is required. Clinicians should be patient, skilled in listening, and should keep an "open mind." Patient factors involved in producing misdiagnosis include distrust, fear of being labeled crazy, insistence on secrecy, amnesia, and conscious or unconscious deception.

INTRODUCTION

The diagnosis (Coons, 1980; Greaves, 1980; Kluft, 1985a) and differential diagnosis (Solomon & Solomon, 1982; Coons, 1984; Kluft, 1987a,b,c) of multiple personality disorder (MPD) have been thoroughly reviewed elsewhere as has the clinical phenomenology of this interesting disorder (Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons, Bowman, & Milstein, 1988). With the increasing interest in MPD (Boor and Coons, 1983; Damgaard, Van Benschoten, & Fagen, 1985; Braun, 1985-1989) has come a dramatic increase in the diagnosis of MPD (Coons, 1986) and, unfortunately, a subsequent increase in its misdiagnosis (Kluft, 1988a). The purpose of this report is not to reiterate the description of MPD and its differential diagnosis, but to describe in detail the factors underlying its misdiagnosis and to offer suggestions regarding proper diagnosis.

The misdiagnosis of MPD may be subdivided into two broad categories, false negative diagnosis and false positive diagnosis. These two categories may each be further subdivided into clinician factors and patient factors. These broad categories of misdiagnosis will be discussed in some detail in order to describe the subtle problems involved in the diagnosis and differential diagnosis of MPD.

FALSE NEGATIVE DIAGNOSIS OF MPD - CLINICIAN FACTORS

Clinician factors involved in the misdiagnosis of MPD involve the following:

1. Unfamiliarity with the clinical syndrome of MPD
2. Overly brief diagnostic evaluation
3. Lack of collateral data
4. Disbelief in MPD and/or incest
5. Belief that MPD is rare
6. Inability to listen and/or empathize

Unfamilarity with the syndrome of MPD:

MPD is perhaps most frequently not diagnosed when present because many clinicians are still unfamiliar with the its clinical phenomenology. This is probably due in large part to the lack of education about MPD in clinical training programs. Although this area has not been studied in detail, the situation at Indiana University School of Medicine is probably not dissimilar from what has been occurring nationwide.

Since 1980 I have been lecturing to the first-year psychiatry residents about MPD and the other dissociative disorders in their Course on Clinical Syndromes. Formal lectures to the psychology interns have only occurred in the past two years. Lectures to nursing students and chaplaincy students have been given on an intermittent basis. Until 1989 the junior medical students had been informed in a lecture on the "neuroses" that MPD was rare and not to worry about it, because they would probably never see one. One medical student recently asked his faculty preceptor if MPD was so rare, then why were there three patients with MPD on the inpatient psychiatry service at the university hospital!

Although the current professional literature on MPD has exploded (Coons, 1988a), the same cannot be said of the descriptions of MPD in psychiatric and psychological textbooks. Most current textbook description of MPD are hopelessly out-of-date. The more current descriptions cite "Eve" from the early 1950s (Thigpen & Cleckley, 1954) and "Sybil" from the early 1970s (Schreiber, 1973). Two excellent descriptions of MPD which have bucked this trend appear in the *Diagnostic and Statistical Manual of Mental Disorders Third*

Edition Revised (1987) and the *American Psychiatric Association Textbook of Psychiatry* (Kluft, 1988b).

It has been gratifying to observe the professional growth of residents who have graduated from our program since the dissociative disorders have been included in their curriculum. I have received many phone calls from these former residents when they encountered their first case of MPD. However, it has been much harder to "teach old dogs new tricks." With a few exceptions, colleagues out of training for 15 years or more have been reluctant to seek consultation.

Overly brief diagnostic evaluation:

Although many psychiatric syndromes, such as the affective disorders and schizophrenia, usually can be easily diagnosed in a half-hour diagnostic interview, this is not true of MPD. Although I consider myself an expert on the diagnosis and differential diagnosis of MPD, I generally need two to four hours to come to a diagnostic conclusion, and some cases take considerably longer. In many instances much preliminary diagnostic work has already occurred with the clinician seeking consultation with me. I prefer, however, to take my own clinical history. This history consists of present and past psychiatric histories, past medical history, review of systems, family history, and personal and social histories. An extremely compulsive chronological childhood history is taken in order to uncover periods of memory loss. In addition, much attention is paid to eliciting the symptoms of MPD. The clinician unfamiliar with MPD will find already published symptom checklists helpful here (Greaves, 1980; Kluft, 1984; Putnam, Lowenstein, Silberman, & Post, 1984). Finally, the Minnesota Multiphasic Personality Inventory (MMPI) and Dissociative Experiences Scale (DES) have been found to offer many useful diagnostic clues (Coons & Sterne, 1986; Bernstein & Putnam, 1986).

Unfortunately, most standard psychiatric textbooks offer little help with clinical history taking for MPD. Not only are there no lists of MPD symptoms, but the clinician is left to wonder how to evaluate the patient for a psychogenic memory loss. Although the standard mental status examination contains many questions to evaluate organic memory loss, this is not true of psychogenic memory loss. Probably the most useful tool here is to take a very compulsive chronological history as noted above. Then "holes" in the memory will appear quite obvious. The use of other specialized diagnostic techniques will be discussed in detail later.

Lack of collateral data:

Where an amnesic or dissociative disorder is suspected, collateral interviews with family, friends, ex-therapists, etc., can be invaluable in making an accurate diagnosis (Coons, 1980, 1984). Likewise the review of old hospital records, school records, etc., can also provide diagnostic clues. If the patient has a true dissociative disorder, personality changes almost invariably have been observed by someone. These changes are often quite subtle and are often described as "mood swings," like "living with two people," or "unexpected shifts in behavior." Changes in handwriting style may be found in journals, letters, etc. School records may reveal inconsistent performance. Old hospital records almost invariably reveal comments about "memory loss," markedly descrepant behavior, posttraumatic flashbacks, and other dissociative symptoms.

Disbelief in MPD and/or incest:

The credibility problems in MPD and child abuse have been reviewed extensively by Goodwin (1985), who feels that the clinician's incredulity may protect against feelings of disgust, fear, anxiety, anger, and/or sexuality. Obviously, if one does not "believe" in the diagnosis of MPD, it will never be considered in the differential diagnosis. Although it is known that various types of clinicians are openly hostile to the concept of multiple personality and its treatment (Dell, 1988), the reasons for this are unclear as these clinicians' attitudes have not been studied systematically. Therefore, only speculations and tentative conclusions can be offered here.

Attitudes expressed by such clinicians which I personally have heard both first and second hand which include the following: 1) "These people are liars;" 2) "She has a flair for the overdramatic;" 3) She lives in a fantasy world;" 4) "You (the clinician) are terribly naive to believe this person;" 5) "She's just a schizophrenic." Some clinicians are fearful of MPD. Reasons for this fearfulness may include a lack of knowledge about dealing with MPD, discomfort with dealing with strong affects and impulses, discomfort in dealing with child abuse, discomfort in dealing with demanding or difficult patients, or discomfort in dealing with their own disavowed feelings. Some psychiatric clinicians appear to be so biologically or behaviorally oriented that they do not believe in the unconscious. Others have been so indoctrinated in the Freudian psychoanalytic model that they believe all accounts of incest are fantasy. A few of the older clinicians allow pride to get in their way and refuse to believe that they may have missed the diagnosis in some of their patients.

One argument offered by some clinicians well-versed in hypnosis is that MPD is a hypnotic artifact. Although it is true that hypnosis can produce certain symptoms which superficially resemble MPD (Harriman, 1943; Leavitt, 1947; Kampman, 1976). hypnosis cannot produce the full-blown syndrome of MPD (Coons, 1984: Braun, 1984: Kluft, 1987c). This fallacious argument about the hypnotic production of MPD persists despite the fact that most clinicians make the diagnosis of MPD in most patients without hypnosis.

Belief that MPD is rare:

If one believes that MPD is rare, it will be considered in the differential diagnosis, infrequently if at all. Coons (1986) recently reviewed statistics on the prevalence of MPD and estimated anywhere from 600 to 30,000 cases nationwide. Just recently, Kelly (1988) found that about 1.4% of patients in a large private outpatient psychiatric practice either had MPD or dissociative disorder not otherwise specified. Even more recently, Saxena and Prasad (1989) found that 62 of 2651 (2.3%) patients in a large psychiatric outpatient clinic in India met the DSM-III criteria for dissociative disorder. After reviewing my own current data on the prevalence of MPD in Indianapolis and the data from French (1984) it

appears that MPD probably occurs in one in 10,000 persons in the general population and that there are probably at least 25,000 diagnosed and undiagnosed cases of MPD in the United States. Although MPD is not a common disorder like drug or alcohol abuse, phobias, major affective disorders, or schizophrenia, it is definitely not rare.

Inability to listen and/or empathize:

Listening is an art (Reik, 1948), be it acquired or developed, and it cannot be reviewed in detail here. Unfortunately, some individuals either do not have or cannot develop the ability to listen, and sometimes these same individuals become mental health clinicians, much to the detriment of the profession. Unlike the ability to listen, the ability to be empathetic probably cannot be acquired. Either one is sensitive to another's feelings or one is not. The lack of either the ability to listen or to be empathetic spells disaster in making the diagnosis of MPD. Lacking these abilities usually causes the clinician to miss the diagnosis.

FALSE NEGATIVE DIAGNOSIS OF MPD - PATIENT FACTORS

It is not always the clinician's fault that the diagnosis of MPD is not made. Patient factors in the misdiagnosis of MPD include the following:

1. Distrust
2. Fear of being labeled crazy
3. Insistence on secrecy
4. Amnesia
5. Dissimulation

Distrust:

Trust is on extremely crucial factor in the diagnosis of MPD (Wilbur, 1984). Lacking trust, the patient will not open up and share her innermost thoughts, especially those surrounding child abuse and alter personalities. Often alter personalities observe the therapist a long time before being bold enough to reveal themselves.

This lack of trust is easy to understand. A multiple was usually abused by a parent or parental figure (Coons and Milstein, 1986). If one cannot trust parents, then who can be trusted? Often this same parent was loving as well. This pattern of loving and abuse created a profound confusion in the child and probably contributed to the splitting into alter personalities.

Fear of being labeled crazy:

As in the case of Eve (Thigpen and Cleckley, 1954), other patients with MPD are often fearful of revealing periods of time loss or auditory hallucinations ("inner voices") for fear of being labeled crazy. In my experience the fear of "being crazy" is extremely common in MPD. Therefore, the clinician must be especially attentive to this possibility and offer reassurance that experiencing these phenomena does not make one crazy. Quite the contrary, the development of MPD probably was an ingenious coping device which, in the face of overwhelming trauma or abuse, probably protected the individual from psychosis, or even suicide.

Insistence on secrecy:

In the case of incest or other forms of child abuse, secrecy is of paramount importance to the abuser (Russell, 1986). To be caught abusing a child physically or sexually, the abuser risks divorce, arrest, prosecution, incarceration, or even death. Therefore, the abuser will often make threats against the child. If the "secret" is revealed, the child may be punished severely, beaten, killed, or, something to which they are profoundly attached, such as a beloved pet, may be taken away or killed (Wilbur, 1985). It is little wonder that that many patients with MPD initially fail to reveal their abuse or their symptomatology because of their fear of further abuse or death. Coping with this ingrained fear takes time.

Amnesia:

Often the presenting personality is amnesic for the alter personalities (Coons, 1980). Moreover, the multiple may also be "amnesic" for lost periods of time. In some multiples the discontinuity of time experienced by the various personalities is not perceived as unusual because it has been occurring ever since the multiple can remember. The multiple will often express complete surprise when these periods of lost time are pointed out because she thinks that this is the norm for everyone.

Dissimulation:

According to Kluft (1985b), dissimulation (the hiding of symptoms) of MPD occurs in perhaps 90% of all MPD patients. Kluft recommends that the detection of dissimulation may be accomplished through the use of two further diagnostic maneuvers. The first is through the inquiry about Schneiderian first-rank symptoms (Kluft, 1985b, 1987b). Patients with MPD will often admit to such symptoms as made thoughts, made feelings, or made actions. In fact, they are often quite puzzled by such symptoms. Since the diagnosis of MPD cannot be made until dissociation is actually observed (Coons, 1980), Kluft recommends that a prolonged diagnostic interview will often induce spontaneous switching into an alter personality (Kluft, 1987c).

FALSE POSITIVE DIAGNOSIS OF MPD - CLINICIAN FACTORS

Kluft (1987c) feels that making a false positive diagnosis of MPD is much less common than making a false negative diagnosis, but that the incidence of making false positive diagnoses may rise as the literature on MPD burgeons and lawyers and their clients search for defensive strategies in criminal proceedings. My own data supports this contention. Out of 149 patients attending a dissociative disorders clinic, there were 76 patients with multiple personality disorder and 6 patients with factitious multiple personality disorder. Just in the past year, the author was consulted on three criminal cases where MPD was alleged. Careful examination of the data concerning these individuals, all of whom were standing trial for murder, revealed none to have MPD. Moreover, all were found guilty of first degree murder.

Clinician factors in the false diagnosis of MPD include the following:

1. Unfamiliarity with MPD, factitious disorders, and malingering
2. Overly brief diagnostic evaluation
3. Lack of collateral data
4. Overly suggestible interview technique
5. Unfamiliarity with hypnosis
6. Reluctance to consider new data

Unfamiliarity with MPD, factitious disorders, and malingering:

It is not my intention in this brief report to review the symptomatology of these disorders, as excellent discussions are found elsewhere (Coons, 1980; Resnick, 1984 ; Kluft, 1987a, 1987c; American Psychiatric Association, 1987). Moreover, the clinician contemplating a diagnosis of MPD should be knowledgeable about all of them. In my experience those with factitious or malingered MPD may present with the following characteristics: 1) overly dramatic presentation, especially the personality changes; 2) inconsistency in the presentation of alter personalities; 3) lack of a prior history of MPD; 4) the simulation of the well-known and obvious symptoms of MPD but not of the more subtle symptoms and signs; and 5) lack of knowledge about psychodynamics. However, as Kluft (1987c) indicates, none of these signs are infallible.

The presentation of extremely dramatic dissociation is unusual (Kluft, 1987a,c) and occurs in only about 5-10% of all patients with MPD. For example, in the inpatient unit where I practice, all newly admitted patients attend a multidisciplinary admission conference. In a series of 20 patients with MPD, only one patient was observed to dissociate during that conference. One of her switches was quite subtle and was unnoticed by most observers. However, her second switch into an extremely playful child alter was quite obvious to all. The other 19 patients failed to dissociate despite the anxiety provoking nature of the conference and despite being asked to switch in the case where the diagnosis of MPD was definitely known beforehand. Kluft's (1987a) concept of the "window of diagnosability" is valuable here.

Patients with true MPD are usually quite consistent in their presentation of history and symptoms. exceptions to this rule do sometimes occur. For example, one alter may talk of abuse and another will deny it. However, there is consistency with what each alter presents, unless, of course, therapy occurs over the course of the diagnostic evaluation and an alter suddenly remembers a trauma. In addition, treatment may blur the distinctions between personalities. For these reasons treatment of the underlying "dissociative" psychopathology should never be attempted during a forensic evaluation where MPD is suspected. It is the evaluator's job to evaluate and not treat. Emergency treatment can and should be instituted in psychiatric emergencies, but that is the task for a psychiatric clinician not involved in either the defense or prosecution. If treatment is undertaken by a forensic expert hired to evaluate, then the task of subsequent evaluators is much more difficult (Allison, 1984; Orne, Dunges, & Orne, 1984; Watkins, 1984).

The lack of a history of MPD may be a valuable clue to the discovery of factitious or malingered MPD, but again it is not an infallible sign. As previously mentioned, the history of MPD must be diligently searched for by the use of collateral interviews and old psychiatric records.

Those simulating MPD will often simulate what they and others consider to be the more obvious history and symptoms of MPD. These include a child abuse history, alter personalities, headaches, and auditory hallucinations. The more subtle signs of MPD may not be produced, unless, of course, they are suggested by reading the MPD literature or by talking to others familiar with MPD. Probably the most difficult symptoms to produce accurately are the switching phenomenon and a consistent reproduction of alter personalities over time.

The lack of knowledge of psychodynamics may be a valuable clue in diagnosing simulation of MPD. In a recent court case in which I was asked to consult, the defendant simulated PTSD secondary to his murder of his daughter. Although to a trained clinician the lack of trauma inflicted on the defendant was obvious, to the defendant, who had been the real inflictor of trauma, it was not. Interestingly, as each of his "personalities" worked through the trauma of killing his daughter, there was little genuine affect expressed and all of these "abreactions" looked remarkably like one another.

Overly brief diagnostic evaluation:

In my experience making the differential diagnosis between MPD and malingering is the most difficult of any. It takes time to do a complete history, review old records, and interview collateral sources. The patient must be seen on more than one occasion to check for inconsistencies in history and presentation. In a recent case it took me a month of inpatient observation before I was sure that the patient was factitiously producing symptoms of MPD. This particular patient had an extensive knowledge of MPD from both her reading and having a friend with MPD. In addition, she was highly intelligent and was very skilled at the fabrication of symptoms which had allowed her to go undetected through numerous previous hospitalizations.

Lack of collateral data:

As previously indicated, the collection of collateral data and use of collateral interviews is absolutely essential in the differential diagnosis of MPD. It is perhaps most important in the case of the forensic examination where criminal defendants are most likely to simulate symptoms in order to escape criminal responsibility. Therefore, a high index of suspicion must be maintained in all such cases.

Overly suggestive interview technique:

As clinicians, we are trained to accept what people tell us as the truth. This attitude is fine for the usual clinical situation where patients want help and are not trying to deceive, but in the situation where there is some type of gain present, such as to avoid criminal responsibility or obtain money, extreme caution is advised and a skeptical stance is recommended. Therefore, in such situations interview

technique should be modified so as to elicit only relevant reliable data.

The use of overly suggestive interview technique is one of the most common pitfalls in the production of a false positive diagnosis of MPD. This is true not only of the usual clinical interview, but of the hypnotic or sodium amytal interview as well. In situations favoring the production of deception, whether conscious or unconscious, the clinician must steadfastly avoid the use of suggestion. Questions should be open-ended and should not suggest an answer.

The clinician should understand that deliberate lying, inadvertent fantasy, distortion, and confabulation can all occur under either hypnosis and sodium amytal (Orne, 1979; Diamond, 1980, Karlin, 1983; Kluft, 1987c; Pettinati, 1988). My own experience with such fantasy, confabulation, and outright deception has been extensive. In 1988 I published a case report on the misuse of forensic hypnosis by a police hypnotist with the production of a hypnotically elicited false confession and apparent creation of a multiple personality (Coons, 1988b). A suit brought by the exonerated criminal defendant recently brought an out-of-court settlement of $250,000 against three defendants, including the police hypnotist. Just in the past year I have been involved in three murder cases where the criminal defendants used MPD as a criminal defense. In two of these cases clinicians used overly suggestible hypnotic techniques to inadvertently create multiple personality-like phenomena. In neither case did the clinician follow the American Medical Association (AMA) guidelines on hypnosis (AMA Council on Scientific Affairs, 1985).

At present I am very reluctant to use hypnosis or sodium amytal in the diagnosis of MPD. I generally use these techniques as a last resort in less than 5-10% of patients. I avoid hypnosis entirely in a forensic context where MPD is suspected. If the idea of using hypnosis in a criminal investigation is entertained, the clinician should scrupulously follow the AMA guidelines on hypnosis.

Unfamiliarity with hypnosis:

It should go without saying that the clinician should be thoroughly familiar with the phenomenon of hypnosis before embarking on a diagnostic evaluation using this technique. Unfortunately, such is not always the case, even if one does not use hypnosis, he or she should be familiar with its various phenomena because MPD is a trance or hypnotic disorder (Bliss, 1986). If one has not obtained training in hypnosis during professional preparation, then training should be sought at one of the frequent workshops given several times yearly in various locations around the country by either the Society for Clinical and Experimental Hypnosis or the American Society of Clinical Hypnosis.

Reluctance to consider new data:

Because true multiples both simulate and dissimulate symptoms and those with something to gain, such as avoiding legal responsibility, are often skilled at deception, it behooves the clinician to be patient and maintain an open mind in diagnostic matters. The use of "provisional" diagnoses as provided in the *DSM-III-R* is recommended (American Psychiatric Association, 1987).

Even the best of us are fooled by patients. Therefore, we might as well swallow our pride and be able to change our minds if the new data suggests it. I am reminded of the first patient I encountered who simulated MPD. She had a fairly good history for MPD, and even had data in old psychiatric records suggesting dissociation. After quickly confirming her MPD diagnosis with hypnosis, she was placed in a homogeneous MPD group (Coons & Bradley, 1985). She had all of the criteria previously described for factitious MPD, but that realization came only after consultation with a colleague. I even ignored her admission that she had lied and thought that this admission represented the frequent denials that MPD patients make about their disorder early in treatment.

FALSE POSITIVE FACTORS OF MPD - PATIENT FACTORS

Patient deception may be involved in the false positive diagnosis of MPD. When the deception involving psychiatric symptoms is intentionally produced but involuntarily adopted (i.e., the individual is unable to control the behavior), the person is said to have a factitious disorder with psychological symptoms (American psychiatric Association, 1987). In such cases the only apparent gain is to assume the sick role. When the deception is intentionally produced or feigned and motivated by external incentives such as economic gain, avoidance of responsibility, or escape from criminal responsibility, then the person is malingering (American Psychiatric Association, 1987).

Unfortunately, establishing the diagnosis of factitious MPD or malingered MPD can be an extremely time-consuming task as previously described. This task is somewhat easier if the clinician is thoroughly familiar with factitious disorders and malingering and the many forms that these disorders may take (Resnick, 1984).

CONCLUSIONS

This discussion has attempted to outline the major factors involved in the misdiagnosis of MPD. Although iatrogenesis is usually limited to the clinician, in the diagnosis of MPD and its differentiation from simulation, the participation of the subject is also very important and may lead the clinician to a faulty diagnosis. Although diagnostic errors may account for 20% of all psychiatric malpractice suits and failure to diagnose properly may be the basis of a malpractice suit in the case of suspected MPD (Hardy, Daghestani, & Egan, 1988), these patient factors, including simulation and dissimulation, may relieve the clinician of malpractice liability and ultimately result in a verdict in favor of the clinician if he or she is sued. ■

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