0193-953X/91 $0.00 + .20

Clinical Presentations of Multiple Personality Disorder

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A curious paradox pervades the study of multiple personality disorder (MPD). On the one hand, classic, overt, and florid undisguised MPD is one of the most striking and readily recognized of the mental disorders. On the other, clinical experience and research findings demonstrate that MPD is usually clandestine and covert, one of the most difficult mental disorders to diagnose. Four independent groups of researchers studying series of from 50 to 236 MPD patients found that an average of approximately 7 years had elapsed between the entry of these patients into the mental health care delivery system for symptoms referable to MPD and their receiving an MPD diagnoses.[11,14,45,53]

Clinicians' general lack of familiarity with MPD, skepticism, and low indices of suspicion play important roles in their failure to make the diagnosis in a timely manner. Another factor is the failure of standard mental status and psychiatric history-taking protocols to include inquiries relevant to eliciting the characteristic signs and symptoms of MPD.[32,43] Hopefully, future research will allow the identification of those especially effective questions in structured interviews undergoing field trials,[47,48,58] and they can be used to augment more traditional inquiries.

In my longitudinal study of MPD patients, however, it appeared that the most crucial determinant of difficulty in recognizing the presence of the condition is that "the natural history of the overt presentation multiple personality disorder is not widely known or understood. Multiple personality disorder rarely presents as florid multiple personality disorder. The modal natural history is not what one would infer or deduce from its classical manifestations . . . multiple personality disorder, viewed in terms of its overt manifestations over a longitudinal time axis, is very different in its appearance from what is seen at those moments in which one is allowed a cross-sectional 'vertical' view of its

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inner structure via the outward expression of that structure in several personalities."[26] Instead, to approach a constructive resolution, one must ask: "1. What does multiple personality disorder look like when it does not look like multiple personality disorder as one expects to see it? 2. How can one discover the presence of multiple personality disorder in the absence of classical manifestations?"[26]

Both questions have been studied in the literature[26,28,32–34]; however, the delineation of the natural history of MPD[26] and the development of a number of clinical approaches to its diagnosis* have not addressed an underlying issue of considerable significance: Under what circumstances should the average clinician begin to entertain the possibility that he or she is dealing with MPD? Without further progress in this area, it is unlikely that the profession's index of suspicion will be raised to the level at which a more exhaustive or specialized inquiry will be undertaken on the majority of patients whose presentations are consistent with MPD.

This article will describe common presentations of MPD patients in the hope of raising the reader's consciousness about the manifestations of MPD that he or she is most likely to encounter. It will do so by exploring aspects of MPD that are relevant to the configurations of clinical phenomena one is likely to actually see, demonstrating the impact of those aspects on patients' manifest presentations, indicating the changeability of those manifest presentations over time, and providing a set of abbreviated illustrations of familiar clinical gestalts associated with MPD.

NOTES ON THE HISTORY OF MAKING THE DIAGNOSIS OF MPD

When MPD was considered a rarity, and, moreover, a rarity with dramatic and flamboyant manifestations, little attention was paid to its diagnosis and recognition. Given the prevailing wisdom of the era, it was reasonable to assume that sooner or later, the condition would declare itself. When MPD was thought by many to emerge as an iatrogenic artifact, created by the inappropriate suggestions and interventions of a naive or misguided therapist, the notion of making systematic inquiry about its manifestations on a routine basis was implicitly discouraged. To lead a patient to believe the therapist was interested in a set of phenomena that could constitute an iatrogenic illness would be a major faux pas. Alone among illnesses and mental disorders, the clinically approved approach to MPD in many centers has been to conduct the diagnostic interview without making efforts to discern its presence lest it be created thereby.

Therefore, the emergence of systematic efforts to diagnose and to discern the epidemiology of MPD is a relatively recent phenomenon, which could not occur before there existed (1) a recognition that the condition is sufficiently frequent to merit such inquiries; (2) an aware-

*References 12, 13, 26–28, 32–36, 42, 43, 47, 48, 58

ness that the condition occurs naturalistically apart from interventions that might be seen to induce it; and (3) effective treatment so that it is useful to ascertain its presence or absence. The work of Putnam et al,[45] Coons, Bowman, and Milstein,[14] Schultz, Braun, and Kluft,[53] and Ross, Norton, and Wozney[51] in documenting series of 100, 50, 355, and 236 MPD patients and the increasing numbers of MPD patients being recognized by clinicians sensitized by the new literature on MPD has done much to demonstrate that MPD is not uncommon. DSM-III-R[1] no longer states that MPD is rare; studies reviewed elsewhere[40] demonstrate that such cases are found in large numbers whenever systematic efforts are made to screen for their presence. Follow-up studies[24,26,29] document that such patients, when they receive treatment specific to their conditions, can integrate and hold and build further on these gains.

Despite the ardor with which MPD is alleged to be an iatrogenic disorder, evidence to this effect has yet to be produced. It is abundantly clear that it is quite easy to induce a subject to manifest many of the phenomena of MPD,[15,37,46,55,56] but it is equally demonstrable that the transient enactment of such phenomena does not constitute clinical MPD.[15,37] Because a hypnotist convinces a subject to cluck like a chicken does not produce the genuine article! The interested reader is referred to a symposium and several additional relevant articles.[7,15,21,50]

Contemporary diagnostic approaches take a number of forms. The most common procedures among the pioneer clinicians were the astute observation of and indirect inquiry about clinical signs and suggestive findings, questions about amnesia, and the exploration of these "red flags" in depth. Direct questions about MPD were usually deferred, in consideration of fears of leading the patient, as noted above. Articles by Coons[12,13] and Kluft[28,34] describe these approaches.

Unapologetic direct inquiry about the possibility that MPD may underly certain phenomena is the more modern trend, illustrated well in Putnam's classic text.[43] The clinician beginning to work with dissociative disorder (DD) patients in the 1990s should attempt to understand the concerns that led to a reluctance to explore directly, but he or she need not be constrained by them. Hypnosis and drug-facilitated interviews can be useful adjunctive methods in selected cases.

The polysymptomatic pleomorphic presentation of MPD[26,32] has become more widely appreciated. In seminal articles, Bliss[5,6] demonstrated that MPD patients share symptoms with neurotic, borderline, and psychotic conditions. Accordingly, most workers in the field dedicated themselves to discerning MPD through the kaleidoscopic shifts of these phenomena. Putnam, Loewenstein, and Silberman[44] suggested that MPD should be understood as a superordinate diagnosis, under the rubric of which the signs of many conditions might be encountered. An innovative approach was taken by Loewenstein, Hornstein, and Farber,[42] who "systematized the kaleidoscope" into six symptom clusters, and argued that any patient having (1) process symptoms (overt MPD-like phenomena); (2) autohypnotic symptoms, (3) amnesia symptoms; (4) somatoform presentations, (5) posttraumatic stress symptoms; and (6) affective symptoms might well prove to have MPD. This is a

profoundly useful conceptualization, because it brings the clinician to the point of considering MPD via the observation of suggestive signs of MPD in conjunction with common clinical phenomena which, until recently, were seen as suggesting possible alternative diagnoses.

Approaches based on deepening appreciation of the nature of MPD are emerging. Kluft[20,26,33] found that first rank symptoms, once thought pathognomonic of schizophrenia, were in fact more characteristic of MPD, and could be used as diagnostic clues for MPD. He also demonstrated the fluctuating nature of MPD symptoms, encouraging clinicians to become aware of subtle and intermittent manifestations.[26] Franklin[18,19] was able to describe subtle signs of MPD with sufficient clarity to facilitate clinicians' recognition of the condition.

The Dissociative Experiences Scale (DES) of Bernstein and Putnam[3] has proved a useful screening instrument. Many clinicians use it routinely, subjecting patients with scores of 20 or more to careful scrutiny for MPD. The vast majority of patients with scores more than 40 prove to have MPD.

A final trend is toward the use of structured clinical interviews. Two such instruments have been developed, the Dissociative Disorders Interview Schedule (DDIS) of Colin Ross, MD.[47,48] and the Structured Clinical Interview for DSM-III-R Dissociative Disorders (SCID-D) of Marlene Steinberg, MD.[59] Their strategies are rather different. The DDIS is an easily administered inquiry about consciously perceived and endorsed symptoms of several mental disorders. Its author describes it as 90% sensitive in picking up true MPD without false positives. The SCID-D is a more elaborate instrument with branching options and room for clinician observations and clinical judgement. Its use requires special training. Its author describes it as more than 90% sensitive for true known MPD, and has found that most of those who appear to be false positives prove on follow-up to have had previously undiagnosed DDs. This author finds both to be quite useful. These instruments are the culmination of a process that began in the mid-1970s when the late David Caul, MD, developed the General Amnesia Profile (GAP), and the author wrote the first of several versions of the semistructured Center for the Dissociative States (CSDS) Diagnostic Protocol. These remained unpublished but were widely circulated in workshop settings. Many of their items are reflected in the SCID-D.

Despite exciting advances in the use of psychological testing to assess MPD patients,[2] it would be premature to state that psychological testing has "come of age" with regard to the diagnosis of MPD.

Contemporary clinicians then, have a number of diagnostic strategies at their disposal, all of which have proved useful. They are in a better position to approach making the diagnosis of MPD than were most of the pioneer and master clinicians of a decade ago.

RESIDUAL CONCERNS

Nonetheless, making the diagnosis of MPD remains a problematic enterprise. Notwithstanding the progress outlined above, clinical expe-

rience remains invaluable. After following several MPD patients over time, one becomes highly sensitized to the manifestations of the condition. It is most instructive to observe known MPD patients trying to deny and dissimulate their MPD. Witnessing the subtle manifestations of MPD as they escape total suppression in such instances is the best possible instruction in detecting undiagnosed cases, whose basic adaptation is to dissimulate.[26] Such experience takes time to acquire, and its insights are difficult to teach without close-up videotapes of such patient material.

More important and pervasive, however, is the fact that many conscientious and open-minded clinicians either have been practicing for years without detecting MPD, or are uncomfortable that they are not detecting all of these cases that enter their practice. Even if these clinicians are apprised of the newer advances and instruments and master them, the issue arises of when they should be used. Should every patient be screened with certain questions or a DES? The author, aware of the excess morbidity and mortality associated with misdiagnosing MPD, would argue in favor of such steps but realizes the unlikelihood of their being adopted as routine practice.

Once again, for pragmatic purposes, it is useful to return to the two questions posed earlier, condensed, in essence, to the query: What does MPD look like when it does not assume a "classic" form? From this follows: When should one suspect that MPD is at the root of a clinical presentation and initiate an evaluation process designed to unearth it? To approach the resolution of this concern, it is useful to begin with an exploration of the condition itself.

THE RELATIONSHIP BETWEEN THE INNER STRUCTURE OF MPD AND ITS MANIFEST APPEARANCE

The Nature of MPD

After studying 210 MPD patients Kluft[26] found that "the natural history of multiple personality disorder involves most individuals' making very different presentations over the course of their patient careers. . . . most patients who satisfy DSM-III criteria for multiple personality disorder at some points in time do not satisfy such criteria at others." He was led "to conclude that what is essential to multiple personality disorder across its many presentations is no more than the presence, within an individual, of more than one structured entity with a sense of its own existence."[26]

In sum, the irreducible core of MPD is an persistent form of intrapsychic structure rather than overt behavioral manifestations. At times the alters do little more than persist, having minimal or no appreciable impact on the flow of experience. At other times, some take over executive control in such an obvious manner that classic MPD with clearly alternating alters is manifest. On still other occasions, the alters may exert their influence by impacting on an alter that to all outer appearances is in executive control. The way in which they exert their

influence will determine the clinical picture that results. The situation is analogous to that of many patients who suffer bipolar manic depressive disorder or collagen diseases—the manifest symptoms may wax and wane and appear to be absent, but a diathesis remains and the potential for the recapitulation of the overt pathology persists.

MPD develops when an overwhelmed child who cannot flee or fight adverse circumstances takes flight inwardly, and creates an alternative self-structure and psychological reality within which and/or by virtue of which emotional survival is facilitated. This involves the elaboration of alters, which allows the enactment of alternative approaches to trying circumstances. For example, a young girl experiencing incest may generate an alter to hold the incest experience so that she can remain in her family without conscious awareness of what has befallen her and without being consciously burdened by the fact of her betrayal by someone on whom she remains emotionally dependent. She might create a male alter along the fantasy/wish that such a plight could not befall a boy, or that a boy could better take the pain of such encounters.

"The raison d'etre of multiple personality disorder is to provide a structured dissociative defense against overwhelming traumata and the possible repetition of the same or analogous traumata. The emitted observable manifestations of multiple personality disorder are epiphenomena and tools of the defensive purpose. In terms of the patient's needs, the personalities need only be as distinct, public, and elaborate as becomes necessary in the handling of stressful situations. In childhood cases, investment in separateness and distinctness is usually minimal. Anything further results from hypertrophy or secondary autonomy of these processes, and from whatever narcissistic investments and secondary gains become associated with them."[26]

In short, most of what is so arresting to the beholder about MPD is secondary, and what is hidden is quintessential.

Characteristics of the Personalities

In a similar light, what has been regarded as most characteristic of the personalities, their dramatically enacted polarized behaviors, is also secondary. The groundbreaking surveys by Putnam and his colleagues[45] demonstrated that child alters and those with specialized memory functions are most characteristic. It is important to realize an implicit message that is not articulated in the literature but has been the subject of a presentation[22]—although child alters seem very different from the major alters of the presenting MPD adult patient, they were not very different from the way that human being was at the time of the initial traumatizations. Therefore, what appears to be dramatically different at a later point in time may be the persistence of phenomenology that at one time blended so well with the initial personality presentation that it was indistinguishable. Also, studies of children with MPD[25–27,30,38] demonstrate that many alters are quite similar. This and the finding of personalities within adult MPD patients that are virtually *isomorphic* (V.I.)[20,22] led Kluft to state that the purest form of MPD is its isomorphic variety. That is, when a traumatized child creates another version of him or herself either to hold an intolerable experi-

ence that can be ablated from his or her awareness or to be without awareness of it, MPD has been created intrapsychically. When such an alter emerges and assumes executive control, it is indistinguishable from the original constellation unless areas related to the difficult material are broached. Isomorphic alters appear the same, and if they dominate the clinical presentation, it is very difficult to suspect the presence of MPD. In many ways, despite a strong tradition to the contrary, isomorphic MPD is the true paradigmatic expression of the condition. Once again, despite the historical tendency for clinicians and the lay public to focus upon them, dramatic external differences are not the core of MPD.

Personalities are not separate people. They are alternative ways of configuring aspects of the mental apparatus in relatively stable and enduring manners. Putnam writes, "I conceptualize the alters as highly discrete states of consciousness organized around a prevailing affect, sense of self (including body image) with a limited repertoire of behaviors and a set of state-dependent memories."[43] Kluft says

> "A disaggregate self state (i.e., personality) is the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli. It is organized in and associated with a relatively stable (but order effect dependent) pattern of neuropsychophysiologic activation, and has crucial psychodynamic contents. It functions both as a recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, and/or present and anticipated ones as well. It has a sense of its own identity and ideation, and a capacity for initiating thought processes and actions."[36]

Therefore, what is most important to appreciate about the alters is the adaptational functions and strategies they subserve and enact and that this mission is supported by segregating certain aspects of experience and knowledge from one another in a relatively consistent rule-bound fashion.[57] Their emergence and manifest separateness is not an inevitable and ongoing concomitant of these purposes and processes. This will be addressed further in the next section.

The Personality System

The older literature on MPD focused on the most clearly defined, overt, and polarized alters and paid considerable attention to the differences in characteristics, amnestic barriers, and clashes among them. The impression is given of struggles for dominance and control, of aspects of the mind with a greater or lesser awareness of one another, and asserting different agendas. Indeed, these are common features of the condition, especially when an MPD patient decompensates to the point of requiring intense or hospital care.

It is useful to bear in mind, however, that in most patients with more than a small number of personalities, the alters constitute a system of mind, and many of them subjectively have the experience of relating to one another as if they were actual people. It is not uncom-

mon for significant constellations of individuals, such as family members and/or those involved in their traumatization, to be represented in a direct, derivative, or symbolic fashion within the system of personalities.[41] Consequently, they may have inner relationships, alliances, and enemities and experience themselves as constituting an inner family or society with its own rules and mores. They often attempt to influence one another. If the alter in ostensible control feels the impact of these inner processes or is the subject of their influences, the intrapsychic state, the symptoms, and/or the overt behavior of the patient may be influenced. For example, an alter may experience the animated arguments of two other alters as distressing hallucinations, the verbalized hostile taunts of another alter as command hallucinations urging her toward self-harm, the depressive affective experience of another alter as a "made feeling," the impulse of another alter toward action as an imposed pressure that is not understood, or the fear of an alter toward a situation or object as a phobia or panic attack.

Most alters can exert their influences without assuming executive control and many types do so by their nature or preferentially. For example, one of the most common and difficult type of alter is the inner persecutor, often based on an identification with the aggressor (here, a prior abuser). The inner persecutor attacks, dominates, and torments other alters. Its very nature "requires" a victim alter. This may occur in a scenario dramatized in the inner world of the alters and never become manifest in overt behavior, and it may take the form of seizing executive control and creating circumstances upsetting to other alters. One of the most common avenues of expression for such alters is the intrusion on and victimization of the alter ostensibly in executive control by expression of threats or insults, or by uttering commands for self-damage, which are heard as hallucinations, in the latter case, as command hallucinations. Another is to create made actions; i.e., by intruding into the domain of motor control so that the patient appears to have flung him or herself down a flight of stairs. The alter in charge will report that this action was experienced as imposed rather than willed.

The apparent behavior or subjective state of an MPD patient is often the vector of many interacting forces that are not apparent upon superficial exploration or represent a series of small behaviors or subjective experiences that have occurred in rapid succession and stem from many different sources. This is why the apparent classic signs of MPD are often not in evidence for long periods of time, even when the MPD is in fact quite active.

Aspects of Overtness

Having described the alters as entities and as an interactive system that need not be overt to both subserve defensive purposes and to cause significant mental disorder, one can proceed to explore those factors that determine how overt the classic phenomena of MPD are likely to be in a given case at a given point. This discussion draws heavily from the author's work on the natural history of MPD.[20,22,26,33]

A major factor is the resilience of the host personality, i.e., the

alter that is in executive control most of the time over a given period of time.[8] If the host is relatively resilient and robust, few external stimuli are likely to overwhelm it and prompt the emergence of more specialized alters. Such a host may also be able to suppress other alters for prolonged periods. If such arrangements are fairly stable and life stressors are not excessive, no evidence of overt MPD may exist for years. One very accomplished health professional, who had classic overt MPD through adolescence, when she was able to escape her abusive family, did not dissociate overtly between ages 16 and 29 or between 29 and 59. Amnestic for both her childhood and the events of her 29th year, her history was without signs of MPD and her diagnosis was serendipitous, when she dissociated in what was thought to be the termination phase of her therapy.[22,26] She was treated in the 1970s and remains integrated and well on a 15-year follow-up.

Related to the above is the presence of trauma and stress in the patient's contemporary life. Clinicians appreciate that the more such pressures prevail, the more likely is the emergence of the alters, which were developed to encapsulate the impact of such influences. Some MPD patients only become overt in connection with intercurrent stressors. Others' equilibrium is destroyed by such events—they fail to return to their premorbid covert adjustment even after the problem has passed, because it has stirred up unresolved issues. Experienced clinicians agree that the type of stressors most likely to accomplish this are those that in some way are symbolic of, psychodynamic derivatives of, or isomorphic with the traumata that led to the establishment of separate personalities. Often such events are followed by traumatic dreams, flashbacks, and finally, by the emergence of overt MPD.

A prime dimension of overtness is related to the frequency and length of alters' emergences. Infrequent emergence offers limited opportunities for the phenomena to be witnessed or to leave traces of their occurrence. Emergences that are brief are less likely to be observed, and less likely to leave a host alter with a convincing experience of time loss to be reported to the clinician.

Another dimension is the alters' pattern of cooperation. If it is high the alters may share contemporary memory, try to pass for one another, and come out smoothly in tandem to deal with problem areas. Neither amnesia nor overt differences may be readily apparent. Some MPD patients' systems of alters are organized such that all but one alter are understood by themselves to be in the service of the survival of that remaining alter. In some instances this goes on but is unknown to the host, who experiences the others' intrusions as passive influences, or, as constructive first rank symptoms.[20,26,33] If the alters are in conflict or contention, yet their battles lead to no clear-cut resolution or domination, the patient's clinical picture will be dominated by the ensuing chaos, and borderline or psychotic appearances are not uncommon. Should the alters in conflict be capable of replacing one another in control, one may see the overt fluctuation of clearly defined alters. This relates to the issues of strength and power among the alters, alluded to above.

Another aspect of overtness is the manner in which the alters learn to influence one another. If they do so by inner dialog, no overt signs of MPD may be observed. If they do so covertly, passive influence Schneiderian symptom phenomena may be seen in an apparently unified and nonpsychotic individual. When they do so by verbalized inner threats, the command hallucinations may lead to a quasipsychotic picture. Should they do so by seizing complete executive control, classic overt MPD may become obvious.

Another consideration relates to the alters' amnestic barriers. When alters share contemporary memories, it is easy to discount their overt differences because of the apparently ongoing and continuous nature of their descriptions of their lives. Conversely, when the alters have dense amnestic barriers with regard to contemporary events, even if their overt differences are mild, the observer's attention is repeatedly drawn to the presence of dissociative phenomena, raising the index of suspicion for MPD.

The presence of many similar alters diminishes the likelihood that their switches will attract attention, unless, as noted, overt amnesia serves as a red flag. Recently the author saw in consultation a patient with 10 alters, all designed to be able to pass for one another, playing a major role in her system. Repeated brief spells of intrainterview amnesia led to his appreciating the presence of a skillfully disguised MPD condition.

It is important to appreciate the dimension of secrecy. Sometimes personalities and systems of personalities choose to keep their existence secret and may suppress those alters moved to make revelations. Under such circumstances patients may know of but disavow their MPD. When confronted about MPD phenomena, they may be rationalized away, disavowed, and suppressed for long periods.

When epochal[36] or sequential[16] phenomena occur, overtness may not be appreciated by any observer who is only briefly familiar with the patient. Alters may dominate one at a time for blocks of time rather than in alternation over a brief time span. If the observer encounters an alter that is well-established in its dominance, it may show no apparent signs of MPD or of amnesia.

Commonality of motivation may unify otherwise diverse alters to collaborate and pass as one for long periods; however, when their goals and objectives diverge, the MPD may once again become overt. A common motivation for this is child-rearing. It is not uncommon for the overt MPD to subside with childbirth, only to become overt when the child goes to school or enters adolescence and distances him or herself from the mother.

The alters' investment in their separateness is a self-evident determinant of overtness. In some cases the alters show considerable narcissism. If these pressures are low, the overt expression of differences may be muted, and the alters' press to declare themselves is minimal. Should the opposite prevail, however, there may be a great show of dramatic differences and vociferous insistence that others acknowledge the presence of MPD and behave differently with the different alters.

Another dimension rarely appreciated is the creativity of the MPD patient. When creative ability suffuses the presentation of MPD, the results may be dramatic. Three of the most publicized MPD cases, "Eve," "Sybil," and Billy Milligan, were all accomplished artists.

Some who suffer MPD achieve considerable secondary gain from their illness. Those who come to value it for this purpose, or who encounter others who both reinforce and exploit their condition, may be quite overt.

The following two cases illustrate the interplay of the last several dimensions.

Betty was raised in a log cabin in a primitive rural area, kept away from other influences by her clannish family and subjected to unspeakable (and confirmed) brutalities. The only "culture" she was exposed to was a one-room schoolhouse. By age eight, home and the schoolhouse were the only two buildings she had entered. The only book at home was a Sears catalog. She developed five alters, four named Betty (who differed only in their memories) and one named Betsy, who was more babyish. They tried to keep their existences hidden. Once diagnosed, Betty responded well to treatment and is integrated at 7-year follow-up.

In contrast, Angelique was the daughter of professional parents. A beautiful and brilliant child, her father groomed her to be an actress, taking her to movies, watching television with her, encouraging her in role-playing, filming her, and showing her films of herself behaving differently. He also abused her. She developed numerous dramatically different alters who competed for control and for attention. She sought a career in entertainment. Her alters shared this goal and maintained a continuous contemporary memory; her amazing range of expression was thought to auger a brilliant future. When she attained her first major role, however, the alters competed as to who should play it. On camera, they contended for control. The director did not know what was occurring, but determined that Angelique could not fulfill her apparent potential. She sought treatment, but the alters refused to work toward common goals. Treatment failed. On 10-year follow-up, she is largely dysfunctional, and only occasionally gets minor extra roles and modeling assignments.

Having emphasized how covert a condition MPD is likely to be, how is it possible to understand the overtness so often noted in MPD patients who are in treatment? The process of being diagnosed and entering psychotherapy initiates a major disequilibrium in many MPD patients. As the patient, across increasing numbers of alters, appreciates his or her condition, which can no longer be kept a secret from the therapist, the press for secrecy is reduced in many cases (in a minority it is intensified in the service of denial). The secret having been revealed, the pain that many of the alters have carried is a powerful motivator for their revealing themselves and seeking assistance. As defenses are probed and the traumatic past is reviewed, the situations the alters were created to manage are reactivated in memory and often abreacted in the treatment. Therapy is experienced as a retraumatiza-

tion, which mobilizes the alters' defensive purposes once again. Furthermore, the alters often must be accessed to undertake the treatment. Because of the alters' self-perceived separateness and amnestic barriers, work with one alter may not impact on another, and each (or at least many) must be reached and dealt with individually. For these reasons and many others, the overtness of the MPD condition may appear to be increased by treatment.

THE LONGITUDINAL PRESENTATION OF MPD—A CASE EXAMPLE

It is intriguing to reflect on the myriad symptoms that are associated with MPD and which may dominate its presentation at any given point. In a recent publication[39] the author combined data from the work of Bliss,[5,6] Coons, Bowman, and Milstein,[14] Horevitz and Braun,[19a] Putnam et al,[45] and Ross, Norton, and Wozney[51] to present a composite picture of what is found in MPD cohorts.

"MPD patients demonstrate anxiety symptoms (psychophysiological ≈ 100%; phobic ≈ 60%); panic attacks ≈ 55%; obsessive-compulsive ≈ 35%), affective symptoms (depressive ≈ 90%; "highs" range 15–73%), allied dissociative symptoms (amnesias [range: 57–100%]; fugues [range: 48–60%]; depersonalization [≈38%]; somatoform symptoms (all ≈ 90%; conversion ≈ 60%); sexual dysfunctions (range: 60–84%), suicide attempts (range: 60–68%), self-mutilation (34%), psychoactive substance abuse (≈40–45%), eating disorders (range: 16–40%), sleep disturbance (≈65%), symptoms suggestive of schizophrenia (depending on symptoms, 35–73%), symptoms of posttraumatic stress disorder (PTSD) (70–85%), and the stigmata of borderline personality disorder (70%)."

It is probable that the extent literature understates the prevalence of some phenomena (e.g., self-mutilation and depersonalization) and overstates that of others (e.g., borderline personality disorder [BPD]) is due to the nature of the cohorts studied by the several authors and the instruments they used to acquire their data.

When a clinician is confronted with a patient who endorses such a wide variety of symptoms, either at presentation or over a lifetime's history, often it will be difficult to discern the presence of MPD. The antecedent sections, however, should allow the reader to infer how the interplay of the return of traumatic materials and the interactions of the alters can combine to create any of the above symptoms. This process will be illustrated by the case of an individual whose MPD was finally diagnosed and resolved after an extensive patient career. First, however, the author would like to emphasize that the studies available to date rarely allow the reader to determine whether it is more appropriate to understand some of the symptoms noted as epiphenomena of MPD or as representing the co-occurrence of additional autonomous mental disorders. In the case in point, it is clear (in retrospect) that all were epiphenomena of MPD. The reader is cautioned against generalizing from this example that all psychopathologic findings in a given

MPD patient are due to the MPD. The author is currently working with a patient who suffered partial complex seizures responsive to anticonvulsants and major depression responsive to antidepressants in addition to her MPD which, when resolved, still left the patient with diagnosable borderline personality disorder.

Case Study. As a youngster Josh could not concentrate well in school and was thought to be hyperactive and have attention deficit disorder. A course of stimulants may or may not have been helpful. Teachers found that he often stared in class and did not respond to questions. He was diagnosed as suffering petit mal seizures despite negative electroencephalograms and remained on anticonvulsants into his teens. Bright and talented, Josh's strengths and the sympathy of his teachers for his apparent medical difficulties allowed him to excel academically despite his erratic behavior and performance. He occasionally denied behaviors that were witnessed by others. Some assumed he was lying, but his parents consulted a neurologist. The additional diagnosis of psychomotor epilepsy was made, and additional medications were prescribed.

Upset at his withdrawal in early adolescence, his school insisted on psychological testing and counseling. He was thought to be depressed and placed on medications. His therapist believed he was obsessive compulsive. Josh slowly emerged socially, but became involved with a crowd that experimented heavily with drugs. There were some scrapes with the law. All charges were dropped because he was a minor. His behavior became quite chaotic in his midteens, and his parents brought him for treatment of both his adolescent turmoil and his drug abuse. On a number of occasions he described hearing voices and was placed on major tranquilizers for brief periods. His psychiatrist feared that he would become floridly schizophrenic, but hoped Josh was simply going through adolescent turmoil and struggling with establishing his sexual identity: Josh had reported hearing a voice telling him he was homosexual and commanding him to perform homosexual acts. While drunk, Josh once succumbed to these pressures. Thereafter he took an overdose. He was brought to an emergency room but not admitted.

Despite this turmoil, Josh did well in school, and gained admission to a prestigious university. Toward the end of his senior year of high school he had his first heterosexual intercourse, and this experience seemed to be a watershed for him—he stabilized considerably and pursued girls with noteworthy dedication.

In college Josh had severe insomnia and sought help. His counselor determined that Josh could not tolerate having a roommate because of severe homosexual anxieties. Placed in a single room, Josh did well. He threw himself into the academic and social life of the college and enjoyed himself. He was prone to absenteeism, but his intellect and general assiduity with his studies carried him through. He joined a fraternity but was allowed to live elsewhere with the backing of the counselor. The ostensible rationale was Josh's fears of letting his grades fall. After learning that a close friend was gay, Josh became quite depressed and had several panic attacks. He also heard voices as he had

before. He was placed on small doses of neuroleptics at student health and told he might be schizophrenic.

Josh excelled academically in college and went to medical school. There the workload precluded the pressured socializing and dating he had enjoyed in college. He became recurrently depressed, and when he was depressed he heard voices urging him toward homosexual acts. On occasion he succumbed and was overcome with self-loathing thereafter. His academic performance was good but not outstanding. Absenteeism continued to be a problem, which was not tolerated during his clinical rotations. He received rather forceful confrontations. Throughout medical school he was in psychotherapy with diagnoses of neurotic depression and obsessive-compulsive personality. His inner voices were believed to be related to the latter condition. "Just very vivid compulsions," he was told. Josh began to drink heavily to get to sleep.

Josh took a residency in psychiatry. He hid his increasing alcohol consumption. He began analytic training, but he did not mention either the drinking or the voices to his analyst. He continued to succumb to commands from within to engage in homosexual acts and withheld this from the analyst. When he developed a florid homosexual transference Josh's anxiety became paralyzing. He felt he needed medication. The analyst told Josh that material he was withholding might explain the symptoms. Josh left analysis and embraced biologic psychiatry.

Josh married near the end of his residency training. His wife was upset by his drinking and unexplained absences. She found his forgetfulness trying, and repeatedly caught him in what appeared to be lies. When his wife became pregnant after he had been in practice a few years, he went to an automobile dealership to purchase a "family car" but returned with a used Porsche. He admitted that he could not explain this — in fact, he could not remember what transpired. This was the last straw. His wife left him and terminated the pregnancy.

Josh practiced in a setting that minimized intense patient contact. He remained in treatment for his depression. He failed to pass his boards, falling asleep whenever he tried to study. He blamed this on a success phobia. Gradually becoming aware of Josh's inexplicable impulsive acts, his homosexual escapades, and his unstable relationships, his psychiatrist decided Josh was borderline and so informed him. This depressed and enraged Josh, who changed psychiatrists.

At the age of 42, Josh married a colleague mental health professional. She rapidly became upset with his drinking and his forgetfulness, which she assumed was part of the drinking, and insisted he go to Alcoholics Anonymous. She also was impressed with violent rages whenever he felt neglected. Once sober, his forgetfulness was not improved, and his impulsive homosexual behavior, which was quite ego dystonic, increased. She discovered it. Threatened with divorce, Josh confessed the full spectrum of his symptoms to her. She insisted he see a specialist in DDs; he consented under duress.

At Josh's first interview his DES score was 46 and he endorsed five first rank symptoms, useful indicators of MPD. When he revealed his hallucinations, the doctor asked if the voices within could be addressed.

Josh was surprised to hear the word "yes" within his head. Shortly thereafter an overt switch occurred.

Josh proved to have been the victim of extensive homosexual abuse. An uncle had coerced his participation in a very forceful manner. The uncle first had abused Josh's older brother; this brother also abused Josh sexually and sadistically. Josh developed alters that identified with the uncle and the older brother. Alters also embodied his profound despair, his panic at being subjugated and violated, and his rage. Some encapsulated particularly vicious incidents. One was specialized to do academic (and later professional) work without intrusion from the others. One was quite a "Don Juan," in an effort to keep at bay his fear of being "unmanly."

The symptoms that led to Josh's approximately 10 prior diagnoses all proved attributable to MPD. The apparent attention deficit disorder was related to the unappreciated switching of rather similar alters in school settings, and the hyperactivity to the abrupt emergence of more frantic alters. The petit mal epilepsy was related to withdrawal into a hurt alter that tried not to feel or respond to the homosexual assaults. The psychomotor epilepsy was diagnosed on the basis of the emergence of alters amnestic for and unable to give an account of one another's activities.

His depression was usually due to the despair of an alter who recalled the abuse and was devastated. The depression was perceived by Josh as a made feeling, without an apparent connection to any cause or precipitant, and was assumed to be psychobiologic. The obsessive compulsive diagnosis was based on the intrusions of other alters' thoughts and issues into Josh's awareness in a driven manner, and upon what appeared to be ritualized behavior as (1) Josh did and undid things as alters with different motivations seized executive control or influenced the alter in control and (2) as Josh drove himself to do things repeatedly in an attempt to overlearn to compensate for what he perceived as an unreliable memory.

Josh's psychoactive substance abuse proved related to his awareness that his behavior was out of his own control; he was making an effort to blunt his psychological dissociation with chemical dissociation. The fluctuation of his alters and their intrusion into the awareness of the alter understood to be "Josh" led to the chaos that occasioned the adolescent turmoil or adjustment reaction of adolescence diagnosis. The hearing of the voices of other alters, internal persecutors, making disparaging insults, or commanding ego-dystonic behaviors, were the basis of putative schizophrenic diagnoses. Josh's insomniac sleep disorder proved related to his fear of falling asleep for fear of losing control to other alters; his falling asleep with studying also proved to be caused by the inner persecutors' efforts to make him feel subjugated and inadequate (because he could not advance academically without his boards). His panics occurred when alters that were afraid of homosexual assault were triggered to near emergence by stressful events, such as having to room with a man. The ego-dystonic homosexuality was related to inner persecutors terrifying scared child alters into

compliance with their commands by reiterating the threats that had scared Josh into submission as a boy. The chaos of Josh's life at times, caused by the switches and incursions of numerous alters, approximated the life circumstances of a person with BPD.

Josh has done quite well in treatment and has been free of all medications for several years. Interestingly, when the historical antecedents of most of the symptoms noted above were explored and abreacted, they lost their intensity and subsided completely. A few persist and are the subject of ongoing therapy. It is instructive that there is no current evidence for an affective disorder, despite the longstanding and persistent affective symptoms.

COMMON PRESENTATIONS OF MPD

Studies have addressed the manner in which MPD patients present.[20-23,25-27,31,33] Approximately 20% of MPD patients spend the majority of their adult lives in an overtly MPD adaptation. Of these, approximately only 6% make a consistent overt and florid attention-seeking appearance on an ongoing basis at certain periods in the course of their patient careers; the remaining 14% are overtly MPD on an ongoing basis for long periods, but they do not call attention to themselves and try to pass with their condition remaining covert.[26] Forty percent present with signs that could easily alert a clinician with a high index of suspicion, and the remaining 40% are very highly disguised indeed, and are usually found only if efforts are made to explore for MPD even in a patient who offers no strong suggestive signs, or as defenses are eroded in the course of therapy. The author found such individuals in the course of field testing the CSDS and in the course of treating patients once he had become sensitized to the subtle signs of MPD.

In a series accumulated largely in the 1970s, approximately 5% of 210 MPD patients presented self-diagnosed. The author's experience is that as the public has become more aware of MPD and its manifestations, this percentage has increased, especially in the practices of those who have published widely. A recent phenomenon, the impact of which has yet to be determined, is a sequela of several forms of treatment that cultivate attention to the "inner child" phenomenon. The author recently has seen several patients whose involvement with such ideas became so intense that they presented with the subjective conviction that they suffered MPD, even though they did not fulfill diagnostic criteria. He has also seen three patients with hidden MPD that was unearthed inadvertently in the course of such treatments, two of whom, in their denial, were sure that their MPD was an iatrogenic artifact.

Before offering a typology of MPD presentations, two observations must be emphasized. First, the most common presentation of MPD remains the patient who has had a long patient career and/or appears to be a treatment failure. Second, although some MPD patients remain in

one presentation, most demonstrate several different presentations over the course of their patient careers, as in the case of Josh. Any patient with either of these characteristics deserves careful scrutiny for MPD. As a complement to the example of Josh, the following vignette illustrates an extreme version of the treatment failure presentation.

Case Study. A 64-year-old man who had been in treatment for obsessive compulsive disorder and a variety of diagnoses regularly since age 21 and who had received virtually all known verbal and psychopharmacologic treatments appeared to be an intractable obsessive compulsive with a wide range of symptoms and rituals that occupied much of his day as he did and undid a wide variety of actions. After 2 years of unproductive therapy the author hypnotically screened him for MPD. It emerged that the doing and undoing were the actions of opposed alters with coconsciousness, that the obsessions were imposed by alters attacking the personality ostensibly in control, and the compulsions were made actions, also imposed by alters. The condition responded well to psychotherapy. He has remained without obsessive compulsive symptoms for 5 years after his successful integration.

Presentations Noted in Patients Who have Fulfilled Criteria for MPD

Classic MPD. The overt and readily observable behavior of such patients fulfills diagnostic criteria for MPD on an ongoing basis for periods of months or years, or even for a lifetime. Because changes of executive control are frequent and the alters' memory banks are somewhat different, evidence of both different behavior patterns and amnestic episodes can be elicited on interview and from ancillary sources. Although many of these patients dissimulate their conditions and may either confabulate to cover periods of time loss or disavowed behavior or have "amnesia for amnesia" (i.e., they forget that they forgot),[26,28,34] most are readily diagnosed by the observant clinician. Some are so skilled at dissimulation and so forcefully motivated to remain undiscovered that they can mislead experts.

Variant Forms. Such patients have the classic phenomena of MPD, but their manifestations are intermittent or have unique features that obscure their appropriate assessment. *Latent MPD* describes patients whose alters are generally inactive but are triggered to emerge infrequently by intercurrent stressors, many of which are analagous to, symbolic of, or trigger memories of childhood traumata. For example, some MPD patients only become overt when their own children reach the ages at which they had been traumatized, or when their abusers become ill or die. At such moments the phenomena emerge and offer a "window of diagnosability"[28,34] before they subside. Such situations may be suspected by history when a patient reports isolated out-of-character incidents for which personal memory is absent or vague, and/or when the patient's retrospective accounts of his or her childhood show suggestive signs of childhood MPD.[25,27,38]

Posttraumatic MPD is clandestine until the patient experiences an overwhelming contemporary event. Object loss, rape, combat, witnessing of violence, betrayal, and head trauma sufficient to cause or-

ganic amnesia are not uncommon precipitants. The persistence of the overt MPD is variable, ranging from transient "windows of diagnosability"[28,34] to ongoing classic manifestations. Often a review of childhood events reveals a history suggestive of childhood MPD gone dormant. At times the overwhelming contemporary event is the onset of a therapy that taps into the childhood trauma and destabilizes an otherwise compensated MPD patient.

Extremely Complex[36] or *Polyfragmented MPD*[8] occurs when there is a wide variety of alter personalities and their comings and goings are so frequent and/or ephemeral that it is hard to discern the outline of the MPD behind the rapidly fluctuating and switching manifestations. Ironically, the patient has become so multiple that the multiplicity disguises itself and rarely takes a classic form. The patient's subjective experience of confused and fluctuating identity and memory is a useful clue.

Epochal[20,22,36] or *Sequential MPD*[16] occurs when switches are rare —the newly emergent alter simply takes over for a long period, and the others go dormant. Because of the length of the dominant periods and the shock of other alters when they return, the author has referred to this as the "Rip Van Winkle" form of MPD.[20,22] Unless such cases are encountered shortly after the transition (often appearing to be a fugue situation) they are likely to have been missed. They can be suspected in patients with dense amnesia for periods of their adult life, and may require hypnotic or drug-facilitated interviews to be diagnosed. In the author's limited experience with such patients and structured interviews, they often are false negatives.

Isomorphic MPD is not uncommon, and many patients spend considerable time in this adaptation. Here a group of very similar alters are largely in control, and/or the alters try to pass as one. The only overt manifestation may be an unevenness of memory and skills, a fluctuating level of function, and inconsistency that is striking in view of the patient's apparent strengths (e.g., "she's quite bright, but what an airhead!"). The patient almost invariably acknowledges forgetfulness and occasionally time loss. Not infrequently the patient appears to have had several episodes of psychogenic amnesia. The most characteristic presentation is intrainterview amnesia.

Much as isomorphic MPD is puzzling because there is an apparent lack of alternating personalities, so *coconscious MPD* is confusing for its apparent lack of amnesia. Such cases present with apparent alters that know about one another and do not demonstrate time loss or memory gaps. Usually there is amnesia, but it is covered over or relates to events long past, and becomes apparent only in therapy. Such patients will become a form of DDNOS in DSM-IV, which will institute an amnesia criterion.

Possesioniform MPD occurs when the alter that is most evident or the sole manifestation presents itself as a demon or devil. Its importance resides in the readiness with which such manifestations can be mistaken for psychotic conditions. Cultural dimensions are quite important. The author once encountered a physician diagnosed as a paranoid schizophrenic who had immigrated from a culture that believed in

possession. Although now completely assimilated on a conscious level, his abuse-filled childhood and the alters he had formed were consistent with his culture of origin. He was treated successfully with a modification of a ritual indigenous to his birthplace.

Reincarnation/Mediumistic MPD involves presentations in which the presenting alters are egosyntonic within certain unique belief systems but are found to overlie more typical alters. For example, a Gypsy fortune-teller consulted the author ostensibly to discuss communication difficulties with her medium. It emerged that this medium was an alter valued by the patient that was being interfered with by other alters unknown to the presenting personality. She allowed the dystonic aspects of her MPD to be treated and resumed her profession.

Atypical MPD. Atypical MPD involves a significant group of patients that is rarely diagnosed. Many patients with such adaptations are quite high-functioning.[31] *Private MPD* occurs when the alters are aware of one another, and the isomorphic presentation is consciously adapted to pass as one. It was first encountered in a brilliant research scientist who revealed her MPD by accident in the sixth year of a psychoanalytic psychotherapy. Once such patients relax their guard, however, the alters usually are not isomorphic.

Secret MPD. This is closely related to atypical MPD. In secret MPD, the alters, although classic, never emerge except when the host is alone, and unlike the private form, the host is unaware of the alters. Cases that bridge private MPD and secret MPD are more common than either pure form—here the alters that know one another present as unified except when alone, but there are other alters unknown to that cooperative system. Such cases are hard to suspect, but can be considered when a patient is unable to give a good account of his or her private time.

Another form is *Ostensible Imaginary Companionship MPD* which occurs when the patient is found to have an apparent adult version of imaginary companionship with an ego-syntonic entity that is co-conscious and copresent and engages in friendly and supportive dialog with an otherwise socially constricted host. Examination reveals, however, that this entity does assume executive control, and that (usually) other entities are present as well.

Covert MPD. Covert MPD is the truly (if not the historically) classic form of MPD and is the characteristic adaptation of most MPD patients most of the time. It may be seen as an analog of lucid possession,[16] in which entities contend for control and influence without assuming full executive control. The manners in which the alters may influence one another have been discussed, and will not be repeated. Suffice it to say, these manners of exerting influence, in which alters act as "the power behind the throne," usually result in the passive influence experiences associated with Schneiderian first rank symptoms of schizophrenia, a phenomenon first described by Kluft[20,26,33] and confirmed by Ross and Norton[49] and by Fink and Golinkoff.[17] Such patients usually experience their mental life and behavior as out of their control. Their actions bespeak some motivated behavior of which

they are either unaware or unable to avow as their own. They often feel they are responsible for situations that they have not willed to occur, but into which they are thrust by actions that they feel subjectively have been imposed upon them rather than selected by them. They often do not have the subjective sense of an internal locus of control. Covert forms may be subdivided roughly into puppeteering (hapless or accepting), phenocopy, somatoform, and orphan symptom varieties.

Puppeteering or Passive-Influence Dominated MPD forms occur when the host is dominated by alters that rarely emerge. If the host is unaware of what is transpiring, he or she feels him or herself the hapless victim of influences that force behavior in ways not willed or chosen. If the host is aware, he or she may express him or herself in ways that confuse the interviewer, i.e., "I am Jane (the host) but I am Sarah (the alter dominating Jane's behavior from behind the scenes) now."

Phenocopy MPD is the most important of the covert forms. It occurs when the final common vector of the alter's influences create phenomena that are similar to the manifestations of other mental disorders, or when the upsurge of traumatic materials overwhelms the patient's ego strength. Alters in conflict insistent on their thoughts, and cancelling out one another's actions may mimic obsessive compulsive disorder. Alters' harassment of one another may lead to a decompensated hallucinated presentation resembling an acute schizophrenic episode. Alters with different mood states influencing the host in turn may, by their lengths of control and patterns of switching, approximate the appearance of any of the affective disorders. Those in contention may create the chaotic appearance of a BPD (well-discussed by Solomon and Solomon[54]), and so on. The incursion of painful flashbacks may cause the patient to driven and superficially chaotic behavior, especially if the flashback is unconscious, (see Blank's review[4]) and there is no apparent rhyme or reason to what occurs.

The alert clinician, aware of phenocopy presentations, should consider MPD whenever a patient who appears to have another mental disorder fails to improve with the application of a therapy appropriate for that condition or if the condition is associated with a prolonged therapy or a poor prognosis. The rationale for this distinction is as follows. If the condition in question normally should respond rapidly to a discrete intervention, it is appropriate to treat that entity and observe the clinical course. If, however, the condition thought to be present is likely to require prolonged therapy or is unlikely to respond well to treatment, aggressive assessment should be undertaken at once, lest unnecessary morbidity be encouraged by pursuing a potentially misdirected therapy. Therefore, a patient with apparent major depression should be treated in a conventional manner, but if refractory to initial interventions, reassessment of the diagnosis should accompany aggressive treatment. Conversely, if a patient is thought to suffer BPD it is wise to consider from the first whether a DD is present because this condition has a less predictable response to therapy and is frequently confused with MPD. A useful approach to suspected phenocopy pre-

sentations would involve the DES and a straightforward interview for signs of MPD, or possibly a structured interview. Another useful screen is the Hypnotic Induction Profile (HIP) of Spiegel and Spiegel.[58] A patient with high scores on both the DES and HIP is much more likely to have MPD than any other condition.

It is the author's experience that the majority of phenocopy presentations are diagnosed with relative ease by making detailed inquiries about apparent first rank symptoms. Usually further signs of dissociative phenomena are elicited, and the patient either switches or shows more evidence that this line of inquiry will be productive.

Somatoform MPD presentations are very common. They occur when the discomfort associated with a painful event is reexperienced, with no conscious connection between the symptom and the historical event, i.e., somatic memory. The author was called to see a woman on a surgical floor with proctalgia and the sensation of a foreign mass in her rectum. There were no organic findings. Inquiry revealed that she had MPD, and the host was feeling the sensations another alter had experienced during a painful anal rape of which the host was unaware. In 2 years of consultation-liaison work, the author found over a dozen MPD patients by exploring such symptoms.

Orphan Symptom MPD presentations are closely related to all of the covert categories. Dissociating patients are prone to divide their painful experiences along the behavior, affect, sensation, and knowledge (BASK) dimensions described by Braun.[9,10] The intrusion of any such element into the ongoing mental life of a patient should initiate the search for a DD—an unwilled motor act, the unexplained intrusion of a strong affect, a sensation for which no medical cause can be found, or intrusive traumatic imagery. In a recent case a patient with drug-refractory panic attacks was found to have covert MPD—the panics occurred whenever a youthful alter, often coconscious with but unknown to the host, became upset and terrified. The adult patient could not explain the onset of the panics, but to the child alter, each has occurred in response to a specific trigger.

Miscellaneous Presentations of MPD. These encompass a wide variety of manifestations. *Switch-Dominated* is a not-infrequent presentation. In this form the switch process is occurring so frequently and/or rapidly that it rather than amnesia or the clear emergence of alters dominates. The patient appears bewildered, confused, and forgetful. This is most common in the extremely complex MPD patient with large numbers of alters. Not uncommonly the patient is thought to have an affective disorder, a psychosis, an organic mental syndrome, or a seizure disorder.

Ad Hoc MPD is a very rare form in which a single helper alter that rarely emerges persists and creates a series of short-lived alters that function briefly and cease to exist. The helper may speak to the host inwardly to advise on how to frustrate inquiries. It is suspected when a history suggests MPD or recurrent fugues, and no alter can be found to account for the missing time. In fugues, there is no persistence of this unusual form of helper alter.

Modular MPD is also quite uncommon but most instructive, occuring when usually autonomous ego functions become personified and split and when personalities are reconfigured from their elements when mobilized. More standard alters may or may not be present. Such patients have an "MPD feel" about them, but once one has talked to an apparent alter one may appreciate its vagueness and may never encounter it in exactly the same way again. Here the dissociative process has become far more extreme than in personality formation per se. The few patients in whom this form has been found have been seriously abused, brilliant, and creative. All but one has been computer literate since childhood. There are clear analogies between this form of dissociative defense and computer functioning, and it may well be that this form will be seen with increasing frequency in the future. In all cases thus far seen, the common factors have been stellar brilliance, bizarre symptoms, and an inconsistency in the manifestations of the apparent alters, who appear generally similar on repeated encounters, but never quite the same.

Quasi-Roleplaying MPD was very rare prior to 1985, but is seen with increasing frequency. The patient is trying to disavow genuine MPD. A personality plays out what has been learned of the other alters as deliberately enacted roles, and then informs the interviewer that he or she is feigning MPD. In another form, the patient immediately follows up apparent alter behavior with statements that the patient is aware of what has occurred and has willfully generated it. With further assessment, it is discovered that the patient is upset about the possibility that the diagnosis is MPD, and is attempting to preempt the chance of receiving the diagnosis. In the 1970s through the mid 1980s this was seen virtually exclusively in mental health professionals. Now it is not rare in sophisticated lay persons.

Pseudo-False Positive MPD, unlike quasi-roleplaying MPD was quite common in the 1970s and the early 1980s, but has rarely been encountered since MPD became more widely recognized. The patient makes a questionable presentation that is clearly based on a well-known case or is so flamboyant as to appear contrived. The presentation is dropped as soon as the patient appreciates that the clinician is competent, caring, and interested in him or her as a distinct human being rather than as a curiosity. It is a desperate patient's attempt to convince the clinician that he or she suffers MPD, and is generated by the patient's anticipation of incredulity. It almost always backfires, however, and, with increasing acceptance of MPD in the United States, it is vanishing. The author, however, has heard reports of similar presentations in countries where attention to MPD is at a much earlier stage of sophistication.

SUMMARY

It is hoped that this discussion of MPD will discourage stereotypic thinking about this condition and encourage the inclusion of MPD in virtually all differential diagnoses. The major thrust of what has been

learned about the natural history of MPD is that most patients with this condition spend most of their lives not manifesting their MPD in classic manner. The typical presentation of MPD is the tip of a rather large iceberg. Covert and other nonclassic presentations are much more characteristic. An appreciation of this will help the clinician approach the diagnosis of MPD with a heightened sensitivity to the possibility of encountering it within his or her practice.

REFERENCES

1. American Psychiatric Association: Diagnostic Manual of Mental Disorders, ed. 3, revised. Washington, DC, American Psychiatric Association, 1987
2. Armstrong JG, Loewenstein RJ: Characteristics of patients with multiple personality and dissociative disorders on psychological testing. J Ner Men Dis 178:448–454, 1990
3. Bernstein EM, Putnam FW: Development, reliability, and validity of a dissociation scale. J Ner Men Dis 174:727–735, 1986
4. Blank AS: The unconscious flashback to the war in Viet Nam veterans: Clinical mystery, legal defense, and community problem. *In*: Sonnenberg SM, Blank AS, Talbott JA (eds): The Trauma of War: Stress and Recovery in VietNam Veterans. Washington, DC, American Psychiatric Press, 1985, pp 293–308
5. Bliss EL: Multiple personalities: A report of 14 cases with implications for schizophrenia and hysteria. Arch Gen Psych 37:1388–1397, 1980
6. Bliss EL: A symptom profile of patients with multiple personalities—with MMPI results. J Ner Men Dis 172:197–202, 1984
7. Braun BG: Hypnosis creates multiple personality: Myth or reality? Int J Clin Exp Hypn 32:191–197, 1984
8. Braun BG: Issues in the psychotherapy of multiple personality disorder. *In* Braun BG (ed): Treatment of Multiple Personality Disorder. Washington, DC, American Psychiatric Press, 1986, pp 1–28
9. Braun BG: The BASK (Behavior, Affect, Sensation, Knowledge) model of dissociation. Dissociation 1(1):4–23, 1988
10. Braun BG: The BASK model of dissociation: Clinical applications. Dissociation 1(2):16–23, 1988
11. Braun BG, Gray GT: Report on the 1985 questionaire multiple personality disorder. *In* Braun BG (ed): Dissociative Disorders 1986. Chicago, Rush, 1986, p 111
12. Coons PM: Multiple personality: Diagnostic considerations. J Clin Psychiatry 41:330–336, 1980
13. Coons PM: The differential diagnosis of multiple personality. Psychiatr Clin North Am 7:51–67, 1984
14. Coons PM, Bowman ES, Milstein V: Multiple personality disorder: A clinical investigation of 50 cases. J Ner Men Dis 176:519–527, 1988
15. Dissociation: The David Caul Memorial Symposium Papers: Iatrogenesis and MPD. Dissociation 2:66–104, 1989
16. Ellenberger HF: The Discovery of the Unconscious. New York, Basic Books, 1970
17. Fink DL, Golinkoff M: Multiple personality disorder, borderline personality disorder, and schizophrenia: A comparative study of clinical features. Dissociation 3:127–134, 1990
18. Franklin J: Diagnosis of covert and subtle forms of multiple personality disorder through dissociative signs. Dissociation 1(2):27–33, 1988
19. Franklin J: The diagnosis of multiple personality disorder based on subtle dissociative signs. J Ner Men Dis 178:4–14, 1990

19a. Horevitz RP, Braun BG: Are multiple personalities borderline? Psychiatr Clin North Am 7:69–88, 1984

20. Kluft RP: Epidemiology of multiple personality. Presented at the Annual Meeting of the American Psychiatric Association, Chicago, May, 1979

21. Kluft RP: Varieties of hypnotherapeutic interventions in the treatment of multiple personality. Am J Clin Hypn 24:230–240, 1982
22. Kluft RP: Forms and transformations of multiple personality disorder. Presented at the Annual Scientific Meeting of the American Society of Clinical Hypnosis, Dallas, November, 1983
23. Kluft RP: An introduction to multiple personality disorder. Psychiatric Ann 14:19–24, 1984
24. Kluft RP: Treatment of multiple personality: A study of 33 cases. Psychiatr Clin North Am 7:9–29, 1984
25. Kluft RP: Multiple personality in childhood. Psychiatr Clin North Am 7:121–134, 1984
26. Kluft RP: The natural history of multiple personality disorder. *In* Kluft RP (ed): Childhood Antecedents of Multiple Personality. Washington, DC, American Psychiatric Press, 1985, pp 198–238
27. Kluft RP: Childhood multiple personality disorder: Predictors, clinical findings, and treatment results. *In* Kluft RP (ed): Childhood Antecedents of Multiple Personality. Washington, DC, American Psychiatric Press, 1985, pp 167–196
28. Kluft RP: On making the diagnosis of multiple personality disorder (MPD). *In* Flach FF (ed): Directions in Psychiatry. New York, Hatherleigh, 1985, pp 1–11
29. Kluft RP: Personality unification in multiple personality disorder: A follow-up study. *In* Braun BG (ed): Treatment of Multiple Personality Disorder. Washington, DC, American Psychiatric Press, 1986, pp 29–60
30. Kluft RP: Treating children who have multiple personality disorder. *In* Braun BG (ed): Treatment of Multiple Personality Disorder. Washington, DC, American Psychiatric Press, 1986, pp 79–106
31. Kluft RP: High-functioning multiple personality patients: Three cases. J Ner Men Dis 174:722–726, 1986
32. Kluft RP: An update on multiple personality disorder: Hosp Community Psychiatry 38:363–373, 1987
33. Kluft RP: First-rank symptoms as a diagnostic clue to multiple personality disorder. Am J Psych 144:293–298, 1987
34. Kluft RP: Making the diagnosis of multiple personality disorder. *In* Flach FF (ed): Diagnostics and Psychopathology. New York, Norton, 1987, pp 207–225
35. Kluft RP: Dissociative disorders. *In* Talbott JA, Hales RE, Yudofsky, SC (eds): The American Psychiatric Press Textbook of Psychiatry. Washington, DC, American Psychiatric Press, 1988, pp 557–586
36. Kluft RP: The phenomenology of extremely complex multiple personality disorder. Dissociation 1:47–58, 1988
37. Kluft RP: Iatrogenic creation of new alter personalities. Dissociation 2:83–91, 1989
38. Kluft RP: Multiple personality disorder in children. *In* Van Dyck R, Spinhovven P, Van der Does AJW, et al (eds): Hypnosis: Current Theory, Research, and Practice. Amsterdam, VU University Press, 1990, pp 169–179
39. Kluft RP: Multiple personality disorder. *In* Tasman A (ed): American Psychiatric Press Annual Review of Psychiatry, vol 10. Washington, DC, American Psychiatric Press, 1991, pp 161–188
40. Kluft RP: Hospital treatment of multiple personality disorder: An overview. Psychiatr Clin North Am 14:695–719, 1991
41. Kluft RP, Braun BG, Sachs RG: Multiple personality, intrafamilial abuse, and family psychiatry. Int J Fam Psychiatry 5:283–301, 1984
42. Loewenstein RJ, Hornstein N, Farber B: Open trial of clonazepam in the treatment of posttraumatic stress symptoms of multiple personality disorder. Dissociation 1:3–12, 1988
43. Putnam FW: Diagnosis and Treatment of Multiple Personality Disorder. New York, Guilford, 1989
44. Putnam FW, Loewenstein RL, Silberman EJ, et al: Multiple personality disorder in a hospital setting. J Clin Psychiatry 47:285–293, 1984
45. Putnam FW, Guroff JJ, Silberman EK, et al: The clinical phenomenology of multiple personality disorder: A review of 100 recent cases. J Clin Psychiatry 47: 285–293, 1986

46. Rabinowitz FE: Creating the multiple personality: An experiential demonstration for an undergraduate abnormal psychology class. Teaching of Psychology 16: 69–71, 1989
47. Ross CA: Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment. New York, Wiley, 1989
48. Ross CA, Heber S, Norton GR, et al: The dissociative disorders interview schedule: A structured interview. Dissociation 2:169–189, 1989
49. Ross CA, Norton GR: Multiple personality disorder patients with a prior diagnosis of schizophrenia. Dissociation 1(2):39–42, 1988
50. Ross CA, Norton GR, Fraser GA: Evidence against the iatrogenesis of multiple personality disorder. Dissociation 2:61–65, 1989
51. Ross CA, Norton GR, Wozney K: Multiple personality disorder: An analysis of 236 cases. Can J Psychiatry 34:413–418, 1989
52. Schneider K: Clinical Psychopathology, ed 5. New York, Grune and Stratton, 1959
53. Schultz R, Braun BG, Kluft RP: Multiple personality disorder: Phenomenology of selected variables in comparison to major depression. Dissociation 2:45–51, 1989
54. Solomon RS, Solomon V: Differential diagnosis of multiple personality. Psy Rep 51:1187–1194, 1982
55. Spanos NP, Weekes JR, Bertrand LD: Multiple personality: A social psychological perspective. J Abnorm Psyc 94:361–376, 1985
56. Spanos NP, Weekes JR, Menary R, et al: Hypnotic interview and age regression procedures in the elicitation of multiple personality symptoms. Psychiatry 49: 298–311, 1986
57. Spiegel D: Dissociating damage. Am J Clin Hypn 29:123–131, 1986
58. Spiegel H, Spiegel D: Trance and Treatment. New York, Basic Books, 1978
59. Steinberg M, Rounsaville B, Cicchetti DV: the structured clinical interview for DSM-III-R dissociative disorders: Preliminary report on a new diagnostic instrument. Am J Psychiatry 147:76–82, 1990

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