

FACTITIOUS OR MALINGERED MULTIPLE PERSONALITY DISORDER: ELEVEN CASES

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ABSTRACT

Of 112 consecutive admissions to a dissociative disorders clinic, 10% of patients with symptoms characteristic of MPD ultimately were discovered to have factitious disorder or were malingering. They were compared with 50 MPD patients previously reported. There were few differences in demographic variables, presenting symptoms, or characteristics of alter personalities between the groups. The use of electroencephalograms and the Minnesota Multiphasic Personality Inventory was not helpful in differentiating the two groups. There was a striking difference, however, between genuine MPD and simulators for the presence of symptoms characteristic of either malingering or factitious disorder. Although some cases of simulated MPD are easy to discern, others may be extremely difficult, even for the experienced clinician. The use of collateral interviews and probing for symptoms common to factitious disorder and malingering are invaluable aids in the differential diagnosis of genuine from simulated MPD.

INTRODUCTION

Factitious or malingered multiple personality disorder (MPD) was reported as early as 1978 (Coons), but since then only a few case reports have been published (Orne, Dinges, & Orne, 1984; Kluff, 1987; Coons, 1988; Coons & Grier, 1990; Chu, 1991; Coons, 1991). In 1978 Coons reported on the phenomenon of "pseudomultiplicity" in which hospitalized patients developed MPD-like symptoms by being in close proximity to other patients with genuine MPD. Presumably this phenomenon occurred in patients attempting to gain attention. In 1988, Coons reported a case of apparent creation of an alter personality through the use of extremely suggestible and leading questions while the subject, a criminal defendant, was under hypnosis. Orne, Dinges, and Orne (1984) suggested that Kenneth Bianchi, one the notorious

Los Angeles Hillside stranglers, was fabricating his illness in order to avoid the death penalty. In 1987 Kluff reported six other cases, but remarked that the simulation of MPD was uncommon and fairly easy to distinguish from genuine MPD, largely because of the malingerer's naivete about MPD symptomatology. Coons and Grier (1990) published a case report of a patient with factitious MPD who was also making false allegations of Satanic ritual abuse. This case was thought to be a variant of Munchausen's syndrome (American Psychiatric Association, 1987). Chu (1991) published two case reports of factitious MPD, and, by this time, patients with factitious MPD had become considerably more sophisticated in their simulation of MPD symptomatology; thus, the differentiation from genuine MPD was much more difficult and time consuming. Recently Coons (1991) reviewed the issue of factitious or malingered MPD in homicide defendants, presented a case of malingered MPD, and concluded that the determination of whether homicide defendants were simulating MPD required considerable expertise in both dissociative disorders and forensic psychiatry.

The use of hypnotic techniques, especially when combined with suggestive interview techniques, can considerably influence the diagnosis of MPD. In the laboratory a group of investigators (Spanos, 1986; Spanos, Weekes, & Bertrand, 1985; Spanos, Weekes, Menary, & Bertrand, 1986) have shown that undergraduate students will simulate MPD when faced with the hypothetical situation of having committed homicide, being arrested, and facing criminal charges. In a recent review (Coons, 1991) of factitious or malingered MPD in homicide defendants, it was concluded that a high index of suspicion of malingering is required by any clinician evaluating a homicide defendant alleging MPD.

This preliminary study compares a group of patients having genuine MPD with a small group of malingered or factitious MPD in terms of symptoms, behaviors, and MMPI scores.

METHODS

Between 1984 and 1991 one hundred and twelve patients presented to a dissociative disorders clinic with symptoms suggestive of MPD. Of these 101 were diagnosed with genuine MPD and 11 with factitious or malingered MPD. All were evaluated extensively with a complete psychiatric and medical history, mental status examination, collateral interviews unless refused, intelligence testing consisting of either the WAIS-R (Wechsler, 1981) or Shipley Hartford Vocabulary

Test (Zachary, 1986), and Minnesota Multiphasic Personality Inventory or MMPI (Hathaway & McKinley, 1967). With their consent all of the inpatients (N=45) had a complete physical and neurological examination and electroencephalogram (EEG). The Dissociative Experiences Scale or DES (Bernstein & Putnam, 1986) was added to the diagnostic inventory in 1986.

Diagnoses were made according to *DSM-III-R* criteria (American Psychiatric Association, 1987). Clinically, factitious disorder was difficult to distinguish from malingering since only six patients actually admitted to simulation and the presence of external incentives was not always easy to discern.

The eleven patients who simulated MPD were compared with 50 genuine MPD patients which were previously reported (Coons, Bowman, & Milstein, 1988). On symptoms of dissociation, characteristics of their alter personalities, and MMPI's, results were evaluated statistically by means of a two-tailed Fisher's exact probability test.

RESULTS

Only some of the data from the previously reported 50 cases of MPD (Coons et al., 1988) will be repeated here for comparison purposes. The eleven patients with a factitious or malingered diagnosis had a mean age of 29 years (range 18-45 years) and a mean educational level of 12 years (range 9-14 years). Nine (82%) were female and all were caucasian. Marital status was 45% divorced, 36% single, and 18% married. The majority (63%) were either unskilled (45%) or skilled/semiskilled (18%), and eight lacked a consistent work history. The only significant demographic difference between the two groups was that there were fewer unskilled persons in the MPD control group (Fisher's exact $p = .007$). Only one of the simulated cases presented in a medico-legal context. Interestingly, the mean age of first psychiatric care for the simulating group was age 18 and the mean age of first psychiatric hospitalization was age 19. For the genuine MPD group these values were 21 and 27 years respectively, but this difference was not statistically significant.

TABLE 1
Symptoms of Dissociation and Characteristics of Alter Personality States in Genuine and Simulated MPD

Symptoms & Characteristics	Simulated MPD (N=11) N(%)	Genuine MPD (N=50) N(%)	Fisher's Exact P
Presence of Alters	11 (100)	50 (100)	ns
Amnesic Alters	7 (64)	50 (100)	ns
Alters of Different Ages	7 (64)	33 (66)	ns
Markedly Different Moods	5 (45)	47 (84)	.001
Depressed Alters	4 (36)	37 (74)	.03
Suicidal Alters	4 (36)	31 (62)	ns
Inner Conversations	4 (36)	29 (58)	ns
Discovery of Unfamiliar Possessions	4 (36)	7 (14)	ns
Angry Alters	3 (27)	4 (80)	.001
Different Accents	3 (27)	34 (64)	.018
Protector Alters	3 (27)	15 (30)	ns
Presence of Co-consciousness	2 (18)	42 (84)	.001
Different Handwriting Styles	2 (18)	17 (34)	ns
Markedly Different Dress Styles	2 (18)	16 (32)	ns
Known by Apparent Strangers	2 (18)	9 (18)	ns
Self-Abusive Alters	1 (9)	15 (30)	ns
Unnamed Alters	1 (9)	9 (18)	ns
Rescuer Alters	1 (9)	8 (16)	ns

The two groups were compared on a list of 14 different presenting psychiatric symptoms representing a wide range of dissociative, somatic, affective, psychotic, and substance abuse problems. In only two categories, decreased sexual desire and selective amnesia, did the simulating group show significant differences (Fisher's exact $p = .001$ in both instances). Decreased sexual desire was reported by 84% of patients with MPD but only one (9%) of the simulators reported this problem, while more of the simulators had selective amnesia (64%) compared to those with genuine MPD (6%). The difference in conversion approached significance (Fisher's exact $p = .079$). The simulating group reported less depression, conversion, and auditory hallucinations, but more fugue, substance abuse, depersonalization, somatization, self-mutilation, suicidality, headaches, visual hallucinations, and delusions.

There were no significant differences in the amount of reported physical abuse, sexual abuse, or neglect, although the lesser amount of physical abuse in the simulators was almost significant (Fisher's exact $p = .079$). As in the control group, alleged abusers tended to be primarily parents or parental figures. Although more of the women simulators reported being raped as an adult (50%), this was not significantly different from the control group (26%). Interestingly, in contrast to our earlier study of genuine MPD where child abuse was confirmed in 85% of cases (Coons & Milstein, 1986), abuse in the current simulator group could not be confirmed in a single instance, because most of the simulators refused to give their permission for collateral interviews. Legal problems were reported more frequently in the simulating group (55%). This was not significantly different, however, from the control group (32%). There were five categories in which there were significant differences between the two groups. Table 1 presents the 18 characteristics of alter personalities. The mean number of personality states reported by the two groups was the same (6.2).

There were no reported seizures in the simulating group and all had normal EEGs and neurological examinations. Compared with the MPD group, there were no significant differences.

As shown in Table 2, the MMPI's of 10 simulators revealed higher L, Pd, Mf (calculated for women only), and Pa scores but lower Pt and Si scores. Four (40%) of the simulators had 8-4/4-8 profiles as compared to eight (20%) of those with genuine MPD.

There were no differences in IQ scores between the two groups. Simulators who took the Shipley Hartford Vocabulary Test had an identical mean (111) to those with genuine MPD. The mean full scale WAIS-R IQ scores were nearly identical (99 in the simulator group and 102 in the MPD group). The mean DES scores were higher for the MPD group than for the simulator group (41 and 34 respectively). The mean number of final diagnoses was lower in the simulator group, 2.3 as compared to 3.8 in the MPD control group.

Striking differences between the two groups were observed when they were compared for the presence or absence of symptoms or behaviors common to those seen in either factitious disorder or malingering. (Table 3) Of

TABLE 2
Minnesota Multiphasic Personality Inventory in Genuine
and Simulated Multiple Personality Disorder

MMPI Scale	Simulated MPD (N=10) Mean T-Score (Range)	Genuine MPD (N=42) Mean T-Score (Range)
<u>L</u>	56 (45-64)	49 (34-73)
<u>F</u>	84 (58-118)	84 (46-120)
<u>K</u>	52 (38-62)	49 (33-65)
<u>Hs</u>	70 (48-100)	69 (48-99)
<u>D</u>	78 (49-92)	80 (48-111)
<u>Hy</u>	73 (56-96)	72 (53-93)
<u>Pd</u>	88 (64-109)	83 (53-114)
<u>Mf</u> *	51 (30-63)	46 (26-78)
<u>Pa</u>	84 (68-111)	79 (53-112)
<u>Pt</u>	74 (62-89)	80 (41-101)
<u>Sc</u>	91 (72-120)	92 (52-120)
<u>Ma</u>	64 (40-86)	66 (37-92)
<u>Si</u>	68 (51-85)	71 (40-85)

* Mf values were included only for the women in either group.

the eight symptoms or behaviors characteristic of factitious disorder or malingering which were inquired about in the original study (la belle indifference, exaggeration, persistent lying, pseudologia fantastica, selective amnesia, lack of consistent work history, refusal of collateral interviews, legal problems, and excessively dramatic behavior), all were increased and significantly different from the patients with genuine MPD. Unfortunately, data were not obtained in the original study of MPD patients about other symptoms of simulation listed in Table 3. These symptoms were observed at high levels in the simulating group. Lack of prior dissociation, seeking hospitalization and MPD diagnoses appeared in all of the simulators. These symptoms included a psychological need to assume a sick role or medico-legal context of presentation, highly dramatized presentations without genuine affect, demanding or deprecating attitudes towards care givers, lack of a previous history of illness such as dissociation, many inconsistencies in presentation of symptoms, numerous hospitalizations, lack of observed symptomatology or worsening of symptomatology while under observation, and refusal of collateral interviews or psychological testing (American Psychiatric Association, 1987).

DISCUSSION

To our knowledge this is the first study ever to calculate a ratio of incidence of simulated and genuine presentations of any psychiatric disorder. The presentation of factitious or malingered MPD, which occurs at a rate of 10% in our series, while not uncommon, is certainly not as common as Thigpen and Cleckley (1984) indicated in a brief communication to the *International Journal of Clinical and Experimental Hypnosis*. They said that they had been referred numerous individuals suspected of having MPD since the publication of their book, *The Three Faces of Eve* (1954), and that nearly all were imposters. Their report neglected to mention the exact number of patients seen, diagnostic criteria used, or symptoms and clinical findings.

Although as clinicians, we are trained to always accept what patients tell us as the truth. By doing so, we may contribute to the unnecessary treatment, or even repeated hospitalization, of a small portion of our patients. One could argue that these patients really need treatment anyway, because the need to simulate, surely must be evidence of illness; however, the type of treatment and the prognosis for patients with factitious disorders and malingering, is not at all certain (Rogers, 1988; Meyerson, 1989; Sussman, 1989).

Malingering can occur in many other psychiatric disorders (Resnick, 1984) and MPD is no exception. The potential simulator has had ample opportunity to read many popular books, view a number of movies or soap operas, and watch many television talk shows on the subject of MPD. Almost anyone will be aware of and able to display many of the appro-

TABLE 3
Comparison of Symptoms and Behaviors Common to Factitious Disorder and Malingering Between Those with Genuine MPD and Simulated MPD

Symptoms & Characteristics	Simulated MPD (N=11) N(%)	Genuine MPD (N=50) N(%)	Fisher's Exact p
Desirous of MPD Diagnosis	11 (100)	N.A.*	
Hospital Seeking Behavior	11 (100)	N.A.	
Highly Dramatic Presentation	11 (100)	22 (44)	.001
Lack of Prior Dissociation	11 (100)	N.A.	
Pseudologia Fantastica	11 (100)	4 (8)	.001
Hostile or Demanding Demeanor	10 (91)	N.A.	
Inconsistent Alter Presentation	9 (82)	N.A.	
Depreciating Demeanor	9 (82)	N.A.	
High Exaggeration	9 (82)	11 (22)	.001
Many Inconsistencies in History	9 (82)	N.A.	
Lack of Consistent Work History	8 (73)	12 (24)	.002
La Belle Indifference	8 (73)	17 (34)	.038
Symptoms Only Under Observation	7 (64)	N.A.	
Selective Amnesia	7 (64)	3 (6)	.001
MPD Used as an Excuse	7 (64)	N.A.	
Persistent Lying	6 (55)	5 (10)	.002
Refusal of Collateral Interviews	6 (55)	0	.001
Admission of Faking	6 (55)	N.A.	
Numerous Hospitalizations	6 (55)	N.A.	

*Data Not Available

priate symptoms and learn how to blink and roll their eyes as if they were dissociating from one personality state to another.

Although some simulated cases of MPD may be quite obvious, other cases may be extremely difficult to discern, even for an experienced clinician. It is apparent from the data in this study that the presentation of traditional and expected symptoms and signs, such as different dress, age, or handwriting, is not a reliable indicator of whether the individual has genuine MPD or is simulating the condition. IQ, neurological, and MMPI examination do not help materially. The clinician must look, rather, for the signs characteristic of factitious disorder or malingering. These include chronic severe disability since late adolescence, lack of a consistent work history, dramatic and exaggerated presentation of symptoms, pseudologia fantastica, demanding and depreciating attitudes towards health care providers, refusal of collateral examinations, selective amnesia, and hospital seeking behaviors, and in the case of a factitious disorder, a psychological need to assume the sick role. Clinicians should be extremely suspicious if the patient presents within a medico-legal context because of the criminal's desire to escape responsibility. Clinicians should routinely seek collateral verification regarding symptoms and past behavior.

Finally clinicians should be extremely cautious with the use of hypnosis as a diagnostic maneuver so as to avoid a false positive diagnosis of MPD. Only if the clinician is well trained in its use, should hypnosis be employed in the diagnostic workup. A specific set of hypnosis guidelines, such as those promulgated by the American Medical Association (1985), should be used in forensic contexts. ■

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