Identity Diffusion Presenting as Multiple Personality Disorder in a Female Psychopath

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A female psychopath presented multiple forms of psychopathology, including features of 'multiple personality disorder'. It is proposed that a diagnosis of borderline personality disorder, or the psychodynamic features of borderline personality organisation, should be the exclusion criteria for this condition.
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Multiple personality disorder (MPD) appears to be extremely rare in Europe. Only two reports have appeared in the English literature (Cutler & Reed, 1975; Fahy *et al*, 1989) and one was highly critical of the condition as a diagnostic entity, proposing instead that it should be viewed as a non-specific psychiatric symptom rather than a diagnostic category in its own right. Nevertheless, DSM–III–R (American Psychiatric Association, 1987) and the draft of ICD–10 (World Health Organization, 1990) both include MPD among the dissociative disorders. Fahy *et al* (1989) argue that its inclusion in DSM–III–R has already had a profound effect on clinical practice in North America, as once the diagnosis of MPD is made this becomes the primary diagnosis and treatment is then focused on reintegrating the personality. In forensic practice this may have disastrous consequences in court, when professionals are called upon to give evidence on criminal responsibility, especially in the case of psychopaths. This was found to the cost of several professionals in the case of Kenneth Bianchi, the 'Hillside Strangler', who malingered MPD in an attempt to evade the death penalty.

Differential diagnosis associates MPD with hysterical or dissociative disorders, and excludes the diagnosis in the case of malingering and schizophrenia where reality testing is no longer preserved, although this may be complicated by the finding that 50% of cases have had a previous diagnosis of schizophrenia (Putnam *et al*, 1986). More importantly, diagnostic difficulties may well arise when MPD co-exists with borderline personality disorder (BPD), which is found in 23–70% of MPD patients in different series. Problems may arise from one of the DSM–III–R criteria of BPD – "marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self image, sexual orientation, long term goals or career choice, type of friends desired, preferred values". The differentiation between this criterion and identity disturbance in MPD may not always be sufficiently clear to avoid overlap. Furthermore, the psychodynamic construct of borderline personality organisation includes 'identity diffusion' as one of its core features (Kernberg, 1984).

A case is presented that demonstrates that in the most severe level of borderline personality organisation, or to use phenomenological constructs, in the presence of multiple DSM–III–R axis I and axis II disorders as in psychopathic disorder, it is not possible to make a clear distinction between BPD and MPD.

Case report

S, a 21-year-old white woman, was admitted to the interim secure unit, under section 38 of the Mental Health Act 1983 (legal category 'psychopathic disorder'). She had been charged with intending to destroy or damage property under the Criminal Damage Act 1971, after being found in possession of 11 boxes of matches and a lighter. She was already known to the forensic service, having been previously referred after unmanageable behaviour in a locked ward and confessions to another psychiatrist of repeated arson attempts. She had denied these during subsequent police interrogation and had been released without charges owing to lack of evidence. When interviewed on remand, she at first denied any interest in fire then, quite paradoxically, presented a book containing long, poetic accounts of fires and firesetting described in ecstatic terms, with several paintings of burning buildings. She was discovered to have a second set of prison case notes under another name, and claimed to have five different identities. She described these as having different personalities which presented at different times, each one female, with a name, age, and style of behaviour, most of which were of a profoundly antisocial disposition.

She was born and spent her early life on a large rural council estate. Both parents were single children and came from harsh, loveless backgrounds. Her father was 20 years older than her mother and was over 50 when she was born. In early childhood she believed he was her grandfather. He worked in a local engineering firm but was troubled by

frequent illnesses, suffering both diabetes and ulcerative colitis, for which he required a colostomy. Her mother was cold, showing little affection, and infantalised the patient, buying her dolls up until her 18th birthday. Her younger brother has an unremarkable history to date, but the patient resented that he was a boy, and she wanted to dress him in girls' clothing. The family home was emotionally cold, materially shabby, and socially isolated from the rest of the community.

Despite a normal pregnancy and delivery, S showed developmental delay. She was unable to walk until two years and was investigated aged six years for speech difficulties. Her full-scale IQ was 105, but with a discrepancy – verbal 116, performance 93 – together with "some difficulties in fine motor control". Early school reports describe her as shy, isolated, and slow to produce work, with poor handwriting. She encountered difficulties in transferring to secondary school, and her reports describe increasingly bizarre behaviour, truanting, and a reluctance to abandon childish clothes. S describes beginning to cut her arms from age 11 years, the same year she received a police caution for a hoax telephone call to the fire brigade.

No history of physical or sexual abuse was elicited but her father expressed the importance of discipline during her childhood. Graffiti began to appear on the local estate regarding her sexual orientation, but she behaved well at home, playing with numerous soft toys, listening to music, and reading books on the occult.

At 14 years she was referred to the local social services after she was found hitchhiking near Bristol, having been missing from home for a week. Her behaviour deteriorated at school and she was expelled. A home visit from a social worker revealed a collection of dolls lying in makeshift hospital beds painted with gross disfigurements and injuries. She was considered a bizarre child with uncertainty about her sexual orientation and identity, who had difficulty differentiating between fact and fiction.

At 15 years, S was admitted to an adolescent unit where she frequently mutilated herself, took overdoses, and absconded repeatedly, on one occasion setting fire to a barn. Charged with arson, she destroyed a bed in police custody, and attacked staff and destroyed furnishings in a secure unit. She was sentenced to borstal training, where her self-mutilation continued unabated, but her sentence was subsequently quashed and she was placed in a youth treatment centre. During her three-year stay, S would dress in the clothing of a younger child, intermittently mutilated herself, including abrading her genitalia, was sexually promiscuous, assaultive, smeared faeces, and began to identify herself by other names. She committed another offence of arson when aged 17 years, stating that she wished to go to Holloway Prison or Broadmoor.

She absconded from the youth treatment centre when aged 18 years, lived rough, and spent some time in a children's refuge under the name D. She returned to her children's home and her care order was discharged, with discontinuation of her supervision by the social services after an assault on her social worker. Shortly afterwards she was charged with criminal damage in London after behaving in a bizarre manner in Trafalgar Square, clutching a teddy bear, followed by an attempt to gain access to 10 Downing Street by kicking over barriers. Remanded into custody as M, she smeared faeces, but was withdrawn much of the time and complained of auditory hallucinations talking about her in the third person. After admission to hospital when aged 19 years, under section 37, she absconded within six days. One month later she was placed in emergency foster care, followed by a children's home in Liverpool. Giving the name T she had convinced the authorities she was 14 years old and had been abandoned by her gypsy family. However, during her stay her behaviour deteriorated, she talked to the other children about murders, demonstrated a detailed knowledge of the Mental Health Act, and was discharged when her true identity was learned.

In the following months she was arrested on numerous occasions in shops and supermarkets, where she claimed to hear people talking about her with the result that she would angrily push objects off shelves. She was arrested in the grounds of a royal estate under a fifth name, M, where she had intended to complain to the Queen about her auditory hallucinations and enlist her help to rid the world of evil. She was briefly admitted to two psychiatric hospitals, where she exhibited regressed, childlike behaviour, smeared faeces, stole a doll from a nursery, and on occasions sucked a dummy.

After a second arrest in the grounds of the same estate, she was remanded into custody where she described passivity feelings and claimed she was directed by other people's thoughts. She was admitted to another regional secure unit under section 37, where she abused laxatives but where no further psychotic symptoms were elicited. Her behaviour improved on neuroleptic medication but she absconded when given parole and travelled to London where she stayed in various squats. During the following months she repeatedly came to the attention of the police and various psychiatric services. This usually followed deliberate self-harm or bizarre behaviour resulting in brief admissions, on two occasions with overactivity, disinhibition, pressure of speech, and flight of ideas.

During this period she alternatively presented as C and L, each with a different age, different life story, and associated with somewhat different behavioural patterns. She began to attend regular out-patient appointments as L, where she described her fascination with fires and confessed to setting numerous fires in London. While attending a psychiatric day centre, other clients began to report fires in their homes to the staff. During this period she was interviewed by the police who felt unable to press charges but was arrested for the index offence some weeks later.

During her stay in the secure unit she remained a reticent young woman who insisted on being called P. She was reluctant to discuss personal issues, and had childish attachments to soft toys and an interest in children's books. She was unwilling to discuss her sexuality, but she adopted a genderless appearance and had homosexual liaisons. She made assaults on other patients, one of which was clearly planned, coldly executed, and with homicidal intent. She described mood swings and tension which were relieved by acting out various types of behaviour including self-mutilation, assaults, self-induced vomiting, and firesetting. Firesetting had apparently become the most effective in

recent months and was her predominant preoccupation during admission. After setting a fire in a wastebin and threatening to abscond and burn down the nurses' home, she received special observations within the unit.

At the times when she would co-operate at interview, no psychotic symptoms could be elicited, but she demonstrated a fragmented personality, switching from the speech and mannerisms of a 14-year-old, to a sullen, adult woman, to a surly and abusive teenager, to a co-operative, compliant and grateful patient, all within a single interview. Sometimes she described her adoption of her other identities as unconscious behaviour which related to different aspects of her personality. On other occasions she described it as a deliberate ploy to escape detection. It was observed that some of the names included those of her place of birth and her first social worker.

Physical investigations, including computerised tomography, were normal, but an electroencephalogram (EEG) showed marked posterior slowing most prominent over the posterior temporal regions with a right-sided emphasis. The special-hospitals assessment of personality and socialisation questionnaire revealed a pattern resembling Blackburn's 'secondary' or 'neurotic' psychopath. She scored 37 out of a possible 44 on the Hare 22-item psychopathy scale, placing her in the high range. She also fulfilled the criteria for multiple DSM-III-R diagnoses on axis I (MPD pyromania, with a lifetime diagnosis of schizophreniform disorder and possible atypical bipolar disorder) and axis II (antisocial, borderline and narcissistic personality disorders).

The conclusion of the assessment was that her continuing treatment was beyond the resources of the secure unit, in terms of both length of stay and level of security. It was considered that she posed a grave and immediate danger to the public. After her court appearance she was transferred under a legal category psychopathic disorder to a special hospital on section 37/41.

Discussion

Although fulfilling the DSM-III-R criteria for MPD, this subject would also support Ludolph's (1985) contention that the criteria are excessively vague and open to a wide variety of interpretations. It could also be argued that the patient fulfils the criteria for malingering by intermittently producing symptoms to escape criminal prosecution. However, much of her behaviour appeared designed to bring her to the attention of the authorities rather than to avoid them, albeit with excitement and pleasure in her deceptions and the anxiety engendered in those who attempted to care for her. Overall, there was little to suggest that her symptoms constituted a discrete dissociative disorder but were instead components of more pervasive wide-ranging forms of psychopathology. It might also be argued that the degree of elaboration of her identity disturbance was more refined than the criterion of identity disturbance within the DSM-III-R axis II category BPD. However, her disorder of identity and the accompanying psychopathology is compatible with Kernberg's (1984) psychodynamic concept of identity diffusion within his definition of borderline personality organisation.

Tarnolpolsky & Berelowitz (1987) have explained the separation between the phenomenological construct of BPD (as in the DSM-III-R classification) and the psychodynamic construct of BPD. The latter includes a disturbance of identity in terms of internalised object relations, with lack of an integrated, coherent, and stable sense of self. Early writers such as Deutsch and Winnicott describe the 'as if' personality and 'false self', and later the idea that these individuals had not attained libidinal object constancy. 'Identity diffusion' was the term that Erikson, and later Kernberg, preferred. Kernberg incorporated the concept into his definition of borderline personality organisation which included (a) absence of a stable sense of identity, (b) use of primitive defence mechanisms (splitting and projective identification), and (c) partial retention of reality testing. In psychodynamic terms an individual with identity diffusion has not integrated good self-images with bad, and has instead multiple, contradictory self-images, some good, some bad. These are invoked at different times and in different situations so that a meaningful, integrated image of the self is never formed (Goldstein, 1985).

In a structured interview, identify diffusion will be reflected in a history similar to this patient's, with grossly contradictory behaviour or emotional states and difficulty for the interviewer in perceiving the patient as a 'whole' human being (Kernberg, 1984). Her history would also indicate the most maladaptive level (level III) of borderline functioning, defined by Gunderson (1984), where major objects are perceived as absent, corresponding to a sense of abandonment and resulting in severe separation anxiety, panic attacks, brief psychotic episodes, and desperate efforts to stave off these states with impulsive and dangerous behaviour.

Unfortunately, psychodynamic authors are not in agreement over the association between MPD and BPD. For example, Clary *et al* (1984) believe that primitive defence mechansisms are at the root of MPD and that it is, therefore, a special instance of BPD. In contrast, Horovitz & Braun (1984) argue strongly that MPD is a separate and distinct disorder from BPD and that it is not a special form of borderline personality organisation. However, in their series of patients they did observe that the less well their subjects functioned the more likely they were to receive an additional diagnosis of BPD. Buck (1983) has suggested that some patients with MPD

may be a subset of borderlines, in whom splitting of self and object representations is so severe that the disparate representations are partitioned and manifested in different 'personalities'. In borderline patients it may be more appropriate, therefore, to refer to 'personality fragments' than 'multiple personalities'. In essence, Buck is making the crucial point that the psychodynamic psychopathology exhibited by this group of patients is pre-oedipal as opposed to oedipal, and is, therefore, more appropriately considered a borderline than a hysterical condition.

From the phenomenological perspective, multiple forms of psychopathology presenting at different times over the lifespan and attracting multiple DSM-III-R axis I and II categories, appear to characterise both MPD and psychopathic disorder. Putnam *et al* (1986) supported the existence of MPD as a clinical entity from a review of recent cases, characterising it as a core of depressive and dissociative symptoms with a childhood history of significant trauma, primarily child abuse. Ninety-two per cent of cases were female, 90% presented with depressive symptoms at first contact, 70% with mood swings and suicidal tendencies, and a significant proportion with hallucinations, delusions, appetite disturbance, and mania. Ninety-five per cent had received one or more psychiatric diagnoses before the diagnosis of MPD. Many of these features are also present in subjects with BPD (Docherty *et al*, 1986) and have also been observed in psychopaths. In an unpublished study of subjects detained under the legal category of psychopathic disorder in English maximum-security hospitals, subjects of both sexes were also found to have multiple DSM-III-R axis II disorders and lifetime axis I disorders, particularly women (Coid, in preparation). BPD was the most frequent axis II diagnosis. No cases of MPD were found, but severe disorders of identity were not infrequent and were often associated with criminal behaviour of a sadistic nature. It may also be of significance that Putnam *et al* (1986) observed that EEG testing typically showed a high rate of non-specific abnormalities in MPD, most commonly bilateral temporal lobe slowing. This phenomenon has been associated with psychopathy for many years.

In contrast to the USA, there are no 'experts' collecting personal series of MPD in the UK, private clinics have not offered specific treatment programmes for sufferers, and no major psychiatric journal has an editorial policy to promote research into MPD. However, research has still not specifically addressed the overlap between 'identity diffusion' of BPD and MPD. Fahy *et al* (1989) have argued that MPD should be viewed as a non-specific symptom. This case history would appear to support their view, as it was impossible to separate the criteria for MPD from many of the other forms of psychopathology present, particularly BPD and the patient's borderline personality organisation. If MPD were a discrete dissociative disorder this should not be the case. In future, the problem might be rectified by including BPD, or the presence of borderline personality organisation, as an exclusion criterion for MPD. However, this would be likely to result in a dramatic fall in the reporting of the condition.

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