Differences Between Men and Women With Multiple Personality Disorder

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Estimates of the ratio of female to male patients with multiple personality disorder have varied between 4 to 1 and 9 to 1 (1). Putnam and associates (2) reported on a group of 100 patients, of whom only eight were men. Greaves (3) summarized the approximately 200 cases of multiple personality disorder reported in the world literature up until 1980. He did not report a sex ratio; however, he and earlier reviewers have noted 19th-century reports of men who had the symptoms of multiple personality disorder (4).

The literature includes descriptions of patients with multiple personality disorder who were seen by individual investigators or small groups of investigators (5). To date no one other than Putnam has reported on a sample of patients in which there were enough men to allow statistical comparisons of the characteristics of men and women with multiple personality disorder.

This paper presents an analysis of the differences between 28 male patients and 207 female patients with multiple personality disorder.

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The analysis is based on reports by clinicians throughout North America.

Methods

A 36-item questionnaire was developed based on clinical reports in the literature, discussions with clinicians who specialize in the treatment of multiple personality disorder, and our clinical experience with 21 patients who had multiple personality disorder. The questionnaire requested information from clinicians about the clinical profile of multiple personality disorder patients they had treated. It was sent to 1,729 members of the Canadian Psychiatric Association and to 515 members of the International Society for the Study of Multiple Personality and Dissociation. The methodology of the study is described in detail elsewhere (6).

The sample of patients was divided into males and females, and statistical comparisons of the two groups were done for all items in the questionnaire. T tests were used to analyze continuous data, and chi square tests were used for dichotomous data. The level of statistical significance was p < .05.

Results

A total of 236 patients were analyzed. However, because the sex of one of those patients was not identified by the respondent, comparisons of male and female patients were based on descriptions of 28 male patients and 207 female patients.

Characteristics of respondents.

Of the 236 patients, 64 were submitted by 49 members of the Canadian Psychiatric Association, five of whom also belonged to the International Society for the Study of Multiple Personality and Dissociation. Information about the remaining 172 patients was submitted by 154 members of the International Society for the Study of Multiple Personality and Dissociation. There were no significant differences between respondents who reported about male and female patients in the average number of patients with multiple personality disorder seen, the average number of patients with multiple personality disorder currently in treatment, or the year in which the respondent first treated a patient with multiple personality disorder.

Characteristics of patients.

Male and female patients did not differ in age, marital status, number of children, or number of close relatives with suspected or diagnosed multiple personality disorder. They were similar in the proportion who had experienced physical abuse, sexual abuse, or rape, and in the frequency with which they had been hypnotized before or after they had received the diagnosis of multiple personality disorder.

Male patients had spent an average of 4.2 ± 5.4 years in the mental health system from the time of their first presentation for symptoms of multiple personality disorder to the time they received a diagnosis of multiple personality disorder, compared with 7.1 ± 6.2 years for female patients (p < .02).

Patient's personalities.

The respondents were asked to state whether the patients they described met each of the five diagnostic criteria for multiple personality disorder required by the National Institute of Mental Health Research Criteria (Putnam, personal communication, 1986). The first three of those criteria, which were the DSM-III criteria for multiple personality disorder, are that two or more distinct personalities, each of which is dominant at a particular time, exist within the individual; that the personality that is dominant at any particular time determines the individual's behavior; and that each individual personality is complex and integrated,
with its own unique behavior patterns and social relationships. The first two of those criteria are equivalent to the DSM-III-R criteria for multiple personality disorder.

The remaining two National Institute of Mental Health Research Criteria are that two or more alter personalities must exhibit distinct and alter-personality-specific behavior on at least three separate occasions and that there is evidence of some type of amnesia among the alter personalities. All patients met the first two criteria, and approximately 95 percent met each of the other three.

The only diagnostic criterion on which male and female patients differed was the third criterion concerning unique social relationships. This criterion was met by 88.9 percent of the male patients and 95 percent of the female patients (p<.02). Men and women did not differ in the number of personalities identified at diagnosis or at the time the respondent submitted the report, or in the frequencies with which they manifested various types of personalities, such as child, protector, or persecutor personalities, personalities of the opposite sex or of a different race or age, or personalities identified as demons, other living persons, or dead relatives.

Other psychopathology. Males and females did not differ in the number of previous diagnoses or in the frequency of hospitalization or of treatment with psychotherapy, lithium, antipsychotics, or electroconvulsive therapy.

They did not differ in the number of Schneiderian first-rank symptoms of schizophrenia they exhibited or the frequency of each of the 11 Schneiderian symptoms. They were similar in the frequencies of previous diagnoses of personality disorder, anxiety disorder, schizophrenia, substance abuse, adjustment disorder, multiple personality disorder, somatization disorder, eating disorder, and organic mental disorder. However, 65.2 percent of the female patients had received a diagnosis of affective disorder, compared with 48.1 percent of the male patients (p<.01).

Men and women did not differ in rates of attempted and completed suicide, although 71.3 percent of the female patients had taken overdoses of medications, compared with 50 percent of the male patients (p<.01). Women were also more likely to inflict cigarette burns or other injuries on themselves; 58.1 percent of the female patients had injured themselves, compared with 40 percent of the male patients (p<.04). Men and women slashed their wrists equally often.

More women than men were prescribed antidepressants (71.2 percent, compared with 50 percent of the male patients, p<.01), benzodiazepines (60.3 percent, compared with 44 percent of male patients, p<.03), and nonbenzodiazepine sedatives (60.7 percent, compared with 45.8 percent of male patients, p<.05).

Men with multiple personality disorder engaged in more antisocial activity than women, although men and women did not differ in the proportion who had worked as prostitutes. Of the male patients, 28.6 percent had been convicted of crimes, compared with 9.7 percent of the female patients (p<.01). Only 10.2 percent of the female patients, compared with 28.6 percent of the male patients, had been to jail (p<.02).

Finally, males and females did not differ in frequency of experiencing headaches, a common secondary feature of multiple personality disorder.

Discussion
Analysis of data about this sample of 236 patients provides evidence that men and women with multiple personality disorder resemble each other demographically, in their multiple personality disorder psychopathology, and in other psychopathology. These findings are consistent with Putnam and others' data (2) on a smaller sample.

We suspect that diagnosticians' attitudinal biases may account for our finding that men received a diagnosis of multiple personality disorder more quickly than women. However, the clinically important fact is that both male and female patients experienced a long lag—an average of 6.7 years—between presentation to a mental health professional for symptoms of multiple personality disorder and correct diagnosis.

The items on which men and women with multiple personality disorder differ are consistent with expectations for psychiatric patients in general and for the general population. The women received diagnoses of affective disorder and were prescribed antidepressants more often than men. They also received prescriptions for benzodiazepines and nonbenzodiazepine sedatives more often. They overdosed more often but were less likely to be convicted of a crime or to be sent to jail.

Our finding that male patients with multiple personality disorder are frequently convicted of crimes and sent to jail suggests that there may be many men with undiagnosed multiple personality disorder in prisons. Bliss and Larson (7) have provided preliminary data on rates of dissociative disorders and multiple personality disorder in male offenders and have found them to be high. Coons (8) has estimated that 6,000 cases of multiple personality disorder have been diagnosed in North America. Given that multiple personality disorder is not rare, a large number of undiagnosed cases may exist in clinical and other populations not yet systematically screened for the disorder. Because of the 9-to-1 female-to-male ratio in clinical samples, there may be more unidentified cases of multiple personality disorder among men than among females in North America.

Our findings must be interpreted with some caution because male patients may not have been selected into the respondents' practices at the same rate as female patients, or may not have been selected for reporting in the same way. The sample size was large enough to detect relatively small differences between the groups, however, so the similarities between men and women cannot be
attributed to a lack of statistical power.

In summary, our data indicate that multiple personality disorder manifests itself in a similar way in men and women. If our data are pooled with those of Putnam and associates (2), a sample of 336 patients with multiple personality disorder treated by clinicians throughout North America is generated. Of those patients, 300 (89 percent) are women and 35 (11 percent) are men, yielding a female-to-male ratio of 9 to 1. This ratio can be expected to change over the next decade as high-risk populations are screened for multiple personality disorder and as more clinicians become familiar with the diagnostic cues for this disorder.

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Open Forum

How Psychotherapy Can Help the Schizophrenic Patient

Patricia J. Ruocchio

The schizophrenic is always fighting a battle within his brain. If his mind is not divided against itself, he is fighting against voices, imaginary people, hallucinations, or other terrifying symptoms. Most schizophrenics go on for years fighting and struggling alone without anyone to help make them stronger than their symptoms. They need someone who can be a lifeline to them as they struggle through each day. Without therapy to help them deal with the world as well as with their inner torment, many would be on back wards, victims of suicide, or just barely surviving on the streets. In too many cases, that is exactly what happens.

Medication is invaluable in helping the schizophrenic feel better. I am grateful that for me it takes away some of the 24-hour-a-day intensity of visual distortions, nightmarish states one right after another, and “spacey” attacks. But these symptoms are not all there is to schizophrenia. I have serious emotional problems and residual symptoms such as disorganized thinking, continued delusions, paranoia, and a general fear of the world.

The things that psychotherapy can do make it a necessary complement to medication. Psychotherapy helps with emotional problems that would have been there despite the illness as well as problems that may have developed because of the illness or an early schizoid personality. Therapy can help the schizophrenic develop feelings that are realistic and correct mistaken feelings through hard work and experience with the therapist. Psychotherapy cannot relieve all the symptoms, but it can improve coping mechanisms and help the schizophrenic avoid some symptoms by discovering what triggers them. By talking to a therapist after a symptom occurs or after a psychotic episode, the schizophrenic can understand the psychological and emotional components of the illness and become less afraid and perhaps less prone to have the symptom.

Psychotherapy helps a schizophrenic who lacks the impetus to carry on by himself to move toward some goal, even if it is just getting through another day. Having some person there constantly encouraging me to just do my best to make it through the day has gotten me through some very troubled times.

For the schizophrenic who is lucky enough to be able to participate in psychotherapy, even in a minimal way, the process can often enhance a life that was once only dark and painful. In many cases, it can alleviate some of the worst manifestations of the illness, such as fear and loneliness. It provides a relationship that teaches one how to interact with others. Many schizophrenics believe that they are incapable of having friends. To learn how to relate to another person can be a major breakthrough in beginning the socialization process.

Schizophrenics often feel that they cannot exist with other people. When I see my therapist, he gives me something that inspires

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