Multiple Personality Disorder
A Review and a Case Study

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Abstract: This paper presents an overview of Multiple Personality Disorder, its development, epidemiology and etiology. It also presents a study of a case. The paper also stresses the criteria for diagnosis so professionals can identify cases at an early stage. Different treatment approaches are discussed.

Keywords: Multiple Personality, Dissociative Reaction

Multiple Personality Disorder (MPD) is a major dissociative reaction in which the patient leads two or more lives independentaly, usually alternating. Each personality seemingly possesses the ability to function independently and separately, one in a dominant position, while the other (or others) is kept submerged for a time. This reaction is the ultimate of dissociative progression. More than six thousand cases of MPD have been diagnosed in North America[1] and, since 1986, over 700 scientific articles, chapters, books, etc. have been published.

A classic example of MPD is the famous work of fiction, Dr. Jekyl and Mr. Hyde, written by Robert Louis Stevenson in 1885. The first reported case of MPD was called Exchange Personalities by Aberhardt Torlin in 1791.

An early case of MPD was published by D.S.L. Mitchell in the Medical Repository in 1816, the case of Mary Reynolds.[2] Mary was considered normal until age 18. At 19, she began to have occasional "fits". After one of these attacks, she became deaf and blind for 5 or 6 weeks. After 3 months, she slept for nearly a day, and awoke seeming to know scarcely anything. After 5 weeks of this new life, she slept again, and awoke as her normal self, with no memory of what she had experienced since her recent lapse. The two states alternated irregularly, till the new state gained over her acquired self by the time she was 36. She continued with the new personality until her death.

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Development of MPD

Sexual and physical abuse is most likely to occur during prepubertal and pubertal periods of development. The impact of such traumatic experience is likely to influence many aspects of the child's psychologic development and even other physical growth and development. MPD develops when an overwhelmed child cannot flee or fight adverse circumstances, takes flight inwardly, and creates an alternative self-structure and psychologic reality within which and/or by virtue of which emotional survival is facilitated.

Epidemiology and Etiology

The Dissociative Experience Scale (DES) is a reliable and valid screening instrument. Other screening tests, the Dissociative Disorders Interview Schedule (DDIS) and the Structured Clinical Interview for DSM-III-R Dissociative Disorders (SCID-D), were developed. These permitted the economic screening of large patient samples.[3]

Child Abuse Model

The cause of MPD is supposed to be severe sexual trauma in a child that was so painful that it has to be "split off" or dissociated from the child.[4] Two predisposing factors have to be present. The first is a biopsychological capacity to dissociate, usually identified with high responsiveness to hypnosis. The second is repeated exposure to severe stressful environment, as one might find in an abusive family.

Conceptual Model

Dissociation is defined as the "separation of an idea or thought process from the main stream of consciousness." It is regarded as a powerful concept. Repres-

sion shades into dissociative mechanism as an involuntary putting-out-of consciousness.

Case Report

"Kathy" is a 29 year old white married female who, after having taken an overdose of sleeping pills in her home, was discovered by her husband and admitted to a hospital. This overdose was attributed to her inability to cope with her responsibility as a wife and mother. The husband reported that several times he had found food burning in the oven. On one occasion the patient was saved from a fire in the home but was unable to recall how it started. The patient also denied ever having had a sexual relationship with her husband, although she was the mother of his three children.

The patient's early development was uneventful except for temper tantrums and nightmares. The nightmares began at about age three when the parents would entertain in their home leaving the child to cry for hours. She would eventually fall asleep only to wake up frightened and screaming.

At age four, she had her first traumatic experience. One night she found her father naked in bed with her five year old neighbour. She said that she was stunned with fear and surprise and ran away to her room. Her father followed her and gently persuaded her to take off her clothes and to join him and the other girl in their sexual play. Later, alone in her room, she felt guilty and cried for several hours, denying to herself what had taken place, and only got relief when she attributed what had happened to someone else, whom she called "Pat." The second day when approached by her father and the girl, she insisted on being called 'Pat." Also, she continued to engage in oral sex with the father, for nearly five years.

At age nine she experienced her second traumatic event, when her mother caught her with her father. The mother became angry with the father, wept for some time and insisted on taking her daughter in her bed every night. After a short time, the mother became attached to her daughter sexually in what the mother described as a safer relationship. "Kathy" could not accept this, denied to herself what was happening and attributed it to a new person, "Vera", who continued the relationship with the mother for another five years.

At age 14, she suffered her third traumatic experience. This was rape by an older man, who was her father's best friend. "Kathy" became very depressed, called herself "Debby" and slept away from the mother. At that time, she was described by the parents as being very miserable. She became mute and was admitted to a hospital.

According to the hospital records, she showed a mixture of depression, dissociation and trance-like symptoms, with irritability and extensive manipulation which caused confusion and frustration among the hospital staff.

Following discharge she was seen by a therapist to whom she became very attached. He showed marked curiosity about the different personalities and became fascinated with her case. He suggested hypnosis as a treatment for her condition. His hypnotherapy sessions focused on the rape incident. He felt that "Debby" was the strongest of the personalities. Instead of concentrating on "Kathy", he encouraged "Debby" to dominate the therapy sessions and talk about "Pat" and "Vera", reinforcing their roles as dominant personalities. It was at this period, she terminated her therapy and began to call herself "Kathy", "Pat", "Vera", and "Debby" at different times.

At age 18, she had her fourth traumatic experience. "Kathy" became very attached to a boyfriend in town. Her parents opposed the relationship and refused to allow her to meet with him. Her mother was constantly warning her that men could not be trusted, pointing to her own marriage to her father. The patient became scared, unable to trust either of her parents, and ran away from home to another town. She could not find a job, and her need of money drove her into prostitution. She began calling herself "Nancy".

"Debby" rejected "Nancy" and forced her to overdose on sleeping pills. She was then admitted to a mental hospital where she met her husband, who also was admitted following a suicide attempt. This time, the diagnosis of multiple personality disorder was confirmed.

Diagnostic Criteria

The diagnosis of MPD is missed more often than it is made.[5] A patient with MPD is likely to have had three or more hospitalizations, between three and five erroneous diagnoses and nearly seven years in the mental health system before the diagnosis of MPD is made. Eight criteria have to be present for an MPD diagnosis to be made:

1. Reports of time distortion and blackouts.
2. Reports of being told of behavioral episodes by others.
3. Reports of notable changes in the patient's behavior during which the patient calls himself/herself by a different name.
4. History of severe headaches, seizures, blackouts, dreams or visions.
5. The use of self-referent "we" in the course of an interview.
6. Discovery of writings and drawings unrecognized by the patient as his or hers.
7. Elicitation of other personalities through hypnosis.
8. The hearing of internal voices.

MPD patients must have a careful evaluation.[6] Amnesia for behaviors in court is always dismissed as lying; fugue states appear to be attempts to evade justice; finding things in one's possession looks like stealing; self-mutilation and suicide attempts are seen as manipulation and the use of different names at different times and in different circumstances is interpreted as the conscious use of aliases in order to evade the law.

Suicide

One of the most common presenting features of MPD consists of suicidal ideation and suicide attempts. Suicidality as a presenting symptom was found in nearly in nearly 70% of 100 cases of MPD reported by 92 clinicians throughout North America.[7] Those who attempted suicide were found to have experienced more physical abuse and rape than those who have not attempted suicide.

Treatment

The stages of treatment are:

1. Proper diagnosis and commitment to treatment
2. Abreaction of the trauma
3. Unification of the system
4. Post-unification treatment

Setting limits helps the patient contain and eliminate maladaptive and self-defeating behaviors. It also provides a dyadic model different from past-object relationships. Cognitive therapy, behavior therapy, or a combination of the two is helpful.[8] In fact, rapport, honesty and trust seem to be far more important than the type of therapy used. Integration or fusion, that is the unification of personality into a single entity, is not necessarily the goal for all MPD patients. Internal cooperation and a satisfying life, however, are goals for everyone. Treatment time after diagnosis remains lengthy, averaging 2-5 years. It is also important that the therapist not overinvolve or overidentify with the patient or attempt to do too much.

Pharmocotherapy

There is no known pharmacotherapy for the "core" symptoms of MPD.[9] Moderate improvement with clonazepam is seen in PTSD symptoms, especially in sleep continuity, nightmares, and flashbacks.[10] High doses of prorpranolol improve anxiety, hyperarousal, poor impulse control, disorganized thinking, and rapid or uncontrolled switching in dissociated disorder patients.[11] Benzodiazepines are the safest of all, except that patients develop tolerance, and substance-abuse problems usually arise. Naltrexone is used for control of the addictive components of severe chronic self-mutilation, eating problems and compulsive sexuality.

Self-Trance, Hypnosis and Abreaction in Psychotherapy

Abreaction of the trauma is done under hypnosis. Most fusions occur with one personality at a time, although fusions of several or all at once can be achieved if the hypnotist is skillful and experienced. In abreaction, always address the alter personality who was recently in control of the body and not the legal personality, if that determination is possible. Call on helper or protective alter personalities for assistance if appropriate. Be extremely cautious about touching the abreacting person. Touch may be interpreted as coming from the abuser and could result in aggressive acting out. Orient abreacting

patients to the present. Insist that they open their eyes and look around. Repeatedly identify yourself, the time, and the place. Do not deny the reality of what the abreacting patient is experiencing, always agree that the experience is painful or frightening, and indicate that it is a memory and that the abuse or trauma is not happening now.[8]

Occupational Therapy

This can provide a variety of play and learning experiences to help the patient's alter personality to develop emotional and social skills. Projective and exploratory techniques may include the use of trays, storytelling and drama therapy, as well as traditional art therapy such as painting, drawing, and sculpture.[12]

Conclusion

In summary, a good prognosis for MPD seems to be related to commitment to treatment and to work toward a resolution of separateness, a willingness to try nondissociative coping skills, and the establishment of a therapeutic alliance. Long-term treatment with an experienced therapist and a healthy support network are essential for success.

References

1. Coons PM. The differential diagnosis of MPD, Psychiatr Clin N Am. 1984;7:51-67.
2. Mitchell SL. A double consciousness or a duality of person in the same individual. Med Repository (new series). 1816;3:185-86.
3. Salama AA. Multiple personality, a case study. Can J Psychiatry. 1980 Nov;25(7):569-72.
4. Braun BG, Sachs RG. The development of multiple personality disorder, predisposing, precipitating and perpetuating factors. In: Kluft RP, editor. Childhood antecedents of multiple personality. Washington, DC: American Psychiatric Press; 1985. p. 37-64.
5. Putnam FW, Guroff JJ, Silberman EK, Barban L, Post RM. The clinical phenomenology of multiple personality disorder: review of 100 recent cases. J Clin Psychiatry. 1986 Jun;47(6):285-93.
6. Greaves BG. Multiple personality: 165 years after Mary Reynolds. J Nerv Ment Dis. 1980;168:577-96.
7. Putnam FW. Recent research on multiple personality disorder. Psychiatr Clin N Am. 1991 Sep; 14(3):489-2.
8. Braun BG. Issues in the psychotherapy of MPD. In: Braun BG, editor. Treatment of multiple personality disorder. Washington, DC: American Psychiatric Press, 1986. p. 1-28.
9. Ross CA, Norton GR, Wozney K. Multiple personality disorder: an analysis of 236 cases. Can J Psychiatry. 1989 Jun;34(5):413-8.
10. Loewenstein RJ, Hornstein N, Farber B. Open trial of clonazipam in the treatment of posttraumatic stress symptoms of multiple personality disorder. Dissociation, 1988;1:3-12.
11. Braun BG. Unusual medication regimens in the treatment of dissociative disorder patients: I. Noradrenergic agents. Dissociation. 1990;3:144-50.
12. Sachs RG. The sand tray technique in the treatment of patients with dissociative disorders: recommendations for occupational therapists. Am J Occup Ther. 1990 Nov;44(11):1045-7.