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MULTIPLE PERSONALITY DISORDER- A CASE STUDY

G. Ajithakumari*

Associate Professor, Sree Balaji College of Nursing, BIHER.

***Corresponding Author: G. Ajithakumari**
Associate Professor, Sree Balaji College of Nursing, BIHER.

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

KEYWORDS: Multiple Personality, Dissociative Reaction.

DEFINITION

Multiple Personality Disorder (MPD) is a major dissociative reaction in which the patient leads two or more lives independently, usually alternating. Each personality seemingly possesses the ability to function independently and separately, one in dominant position, while the other (or others) iskept submerged for a time. This reaction is the ultimateof dissociative progression.

Development of MPD

Sexual and physical abuse is most likely to occur duringprepubertal and pubertal periods of development. The impact of such traumatic experience is likely to influence many aspects of the child's psycho logicdevelopment and even other physical growth anddevelopment. MPD develops when an overwhelmed child cannot flee or fight adverse circumstances, takesflight inwardly, and creates an alternative self structureand psycho logic reality within which And/or by virtue of which emotional survival is facilitated.

Aetiology

The Dissociative Experience Scale (DES) is a reliableand 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.

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. Two predisposingfactors have to be present.

The first is a biopsychologicalcapacitytodissociate, usuallyidentifiedwithhighresponsiveness 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 orthought process from the main stream of consciousness."It is regarded as a powerful concept Repressionshades into dissociative mechanism as an involuntaryputting-out-of consciousness.

CASE REPORT

"MS.X 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 stove. 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 wasthe 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 withher five year old neighbour. she said that she wasstunned with fear and surprise and ran away to her room. Her father followed her and gently persuadedher 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 "Pandi." The second day when approached by her father and the girl, she insisted on being called 'Pandi." Also, she continued toengage in oral sex with the father, for nearly fiveyears.

At age nine she experienced her second traumaticevent, 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 inher bed every night. After a short time, the motherbecame attached to her daughter sexually in what the mother described as a safer relationship.

"MS,X" could not accept this, denied to herself whatwas 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. "MS.X" became very depressed, called herself "dandy" 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-likesymptoms, with irritability and extensive manipulationwhich caused confusion and frustration amongthe hospital staff.

Following discharge she was seen by a therapist to whom she became very attached. He showed markedcuriosity about the different personalities and became fascinated with her case. He suggested hypnosis as a treatment for her condition.

At age 18, she had her fourth traumatic experience."MR.X" became very attached to a boyfriend intown. Her parents opposed the relationship andrefused to allow her to meet with him. Her mother was constantly warning her that men could not betrusted, 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 callingherself "Nancy"."Dandy" 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 ismade. Apatient with MPD is likely to have hadthree or more hospitalizations, between three andfive erroneous diagnoses and nearly seven years inthe mental health system before the diagnosis ofMPD 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 behavioural episodes by others.
3. Reports of notable changes in the patient's behaviour during which the patient calls himself/herselfby a different name.
4. History of severe headaches, seizures, blackouts,dreams or visions.
5. The use of self-referent "we" in the course of aninterview.
6. Discovery of writings and drawings unrecognizedby 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.

Amnesia for behaviours in court is always dismissedas lying; fugue states appear to be attempts to evadejustice; finding things in one's possession looks like stealing; self-mutilationand suicide attempts areseen 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.

One of the most common presenting features of MPDconsists of suicidal ideation and suicide attempts.Suicidality as a presenting symptom was found in nearly in nearly 70% of 100 cases of MPD reported by92 clinicians, 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 behaviours. It also provides a dyadic model different from pastobject relationships. Cognitive therapy, behaviortherapy, or a combination of the two is helpfu1. 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 MPDpatients. 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 over involve or overidentify with the patient or attempt todo too much.

Pharmacotherapy

There is no known pharmacotherapy for the "core "symptoms of MPD. Moderate improvement withclonazepam is seen in PTSD symptoms, especially insleep continuity, nightmares, and flashbacks. High doses of prorpranolol improve anxiety, hyper arousal, poor impulse control, disorganized thinking, and rapid or uncontrolled switching in dissociated disorderpatients' Benzodiazepines are the safest of all, except that patients develop tolerance, and substance-abuse problems usually arise Naltrexone isused for control of the addictive components of severe chronic self-mutilation, eating problems andcompulsive sexuality.

Self-Trance, Hypnosis and Abreaction inPsychotherapy

Occupational Therapy

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

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 totry no dissociative coping skills, and the establishment of a therapeutic alliance. Long-term treatmenttwith an experienced therapist and a healthy support network are essential for success.

Nursing Management

Nursing Diagnosis

- Social isolation
- Risk for suicide
- Attention seeking behaviors
- Risk for violence
- Anxiety
- Ineffective coping patterns
- Self-care deficient

Nursing Interventions

- Reinforce positive behaviors
- Promote consistent application of rules
- Maintain consistency of care
- Avoid staff manipulation
- Deescalate aggressive or violent behaviors
- Avoid countertransference
- Boundary management

Implementation of Nursing Interventions

- Behavior reinforcement: Clearly link behaviors to outcomes while avoiding power struggles
- Rules: Set firm limits on behavior and restate rules in a calm, yet assertive manner
- Consistency: As manipulation is common, ensure that all staff members are on the "same page"/li>
- Manipulation: Use open communication to avoid staff manipulation
- Deescalate: Maintain a confident physical stance if conflict occurs or the client demonstrates signs of physical aggression
- Countertransference: Be aware of your own feeling towards an individual; recognize if your own experiences or personal beliefs and assumptions are impacting the manner in which you provide care. Be responsive rather than reactive. Monitor your interaction to ensure that you are meeting the needs of the patient rather than your own needs
- Boundary management: Use caution in humor, especially around patients with paranoid personality traits, as they can easily misinterpret statements
  Nursing Outcomes
- Patient achieves reduced inflexibility of personality traits that interfere with life functioning and interpersonal relationships
- Staff is able to deliver care in a therapeutic manner
- Patient will remain physically safe from harm to self and others
- Communication will be therapeutic and meet the needs of the patient

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