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MULTIPLE PERSONALITY DISORDER (MPD)

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ABSTRACT

Multiple personality describes a state in which the integrated functioning of a person's identity, including consciousness, memory and awareness of surroundings, is disrupted or eliminated. Dissociation is a mechanism that allows the mind to separate or compartmentalize certain memories or thoughts from normal consciousness. These symptoms can interfere with a person‘s general functioning, including social activities, work functions, and relationships. People with MPD often have issues with their identities and senses of personal history. MPD is diagnosed nine times more often in females than in males. MPD is rarely diagnosed in children; despite the average age of appearance of the first alter being three years. Dissociation is a psycho physiologic process that alters a person's thoughts, feelings, or actions so that, for a time, certain information is not associated or integrated with other information as it normally. The goals of treatment for MPD are to relieve symptoms, to ensure the safety of the individual, and to "reconnect" the different identities into one well-functioning identity. Treatment also aims to help the person safely express and process painful memories, develop new coping and life skills, restore functioning, and improve relationships. Hence such other information about multiple personality disorder also described in this review.

KEY WORD: Multiple Personality Disorder, Life Of MPD Person, Types Of MPD, Diagnosis, Treatment, legal issues.

INTRODUCTION

Multiple Personality Disorder: Multiple personality disorder (MPD), is one of a group of conditions called dissociative disorders.[1] Dissociative disorders are mental illnesses that

involve disruptions or breakdowns of memory, awareness, identity and/or perception.[1,2] when one or more of these functions is disrupted, symptoms can result. These symptoms can interfere with a person's general functioning, including social activities, work functions, and relationships. People with MPD often have issues with their identities and senses of personal history.[3, 4, 5]

Figure 1- Multiple personality disorder

The validity of MPD as a category of illness has been questioned by many. Some feel it is only caused by hypnotic induction and not seen in real life.[6, 7]

Description

Multiple personality occurs along a spectrum, and may be mild and part of the range of normal experience, or may be severe and pose a problem for the individual experiencing the dissociation.[8] An example of everyday, mild dissociation is when a person is driving for a long period on the highway and takes several exits without remembering them. In severe, impairing dissociation, an individual experiences a lack of awareness of important aspects of his or her identity.[9] the degree of impairment ranges from mild to severe, and complications may include suicide attempts, self-mutilation, violence, or drug abuse.

It only takes two distinct identities or a personality state to qualify as MPD but there have been cases in which 100 distinct alternate personalities, or alter, were reported. Fifty percent of MPD patients harbor fewer than 11 identities.[9,10] Because the alters alternate in controlling the patient's consciousness and behavior, the affected patient experiences long

gaps in memory— gaps that far exceed typical episodes of forgetting that occur in those unaffected by MPD.[10, 11] the alters have their own names and unique traits. They are distinguished by different temperaments, likes, dislikes, manners of expression and even physical characteristics such as posture and body language. It is not unusual for patients with MPD to have altered of different genders, sexual orientations, ages, or nationalities.[11, 12]

Facts of MPD

- MPD is an illness that is characterized by the presence of at least two clear personality states, called alters which may have different reactions, emotions, and body functioning.[12]
- How often MPD occurs remains difficult to know due to disagreement among professionals about the existence of the diagnosis itself, its symptoms, and how to best assess the illness.[12,13]
- MPD is diagnosed nine times more often in females than in males.[12]
- A history of severe abuse is thought to be associated with MPD.[12,13]
- Signs and symptoms of MPD include memory lapses, blackouts, being often accused of lying, finding apparently strange items among one's possessions, having apparent strangers recognize them as someone else, feeling unreal, and feeling like more than one person.[13]
- As there is no specific diagnostic test for MPD, mental health professionals perform a mental health interview, ruling out other mental disorders, and referring the client for medical evaluation to rule out a physical cause for symptoms**.**[13,14]
- Individuals with MPD often also suffer from other mental illnesses, including posttraumatic stress disorder, borderline and other personality disorders, and conversion disorder.
- People who may benefit either emotionally or legally from having MPD sometimes pretend to have it, as with those who molest children, have antisocial personality disorder, or in cases of Munchausen's syndrome.[12,13]
- Some researchers are of the opinion that sex offenders who truly suffer from MPD are best identified using a structured interview.[14]

History of MPD

Historically, the disorder first gained prominence as a diagnosis during the late nineteenth and early twentieth century's, at which time it was linked closely to hysteria, and often discovered by and treated with hypnosis. In the middle years of this century, the frequency of the MPD diagnosis declined along with the use of hypnosis; the belief that hypnosis induced multiple personality became widespread.[15] several investigators have reported that MPDs

were frequently misdiagnosed as schizophrenics during the period (Boor, 1982; Coons, 1984; Horvitz & Braun, 1984).The reported incidence of MPD has increased sharply in recent years, to what some believe are epidemic proportions.[15, 16]

- The first case of MPD was thought to be described by Paracelsus in 1646. In the 19th century "*dédoublement*" or double consciousness, the historical precursor to MPD, was frequently described as a state of sleepwalking, with scholars hypothesizing that the patients were switching between a normal consciousness and a "somnambulistic state".[16]

- An intense interest in spiritualism, parapsychology, and hypnosis continued throughout the 19th and early 20th centuries, running in parallel with John Locke's views that there was an association of ideas requiring the coexistence of feelings with awareness of the feelings. Hypnosis, which was pioneered in the late 18th century by Franz Mesmer and Armand-Marie Jacques de Chaste net, Marques de Puységur.[16,17]

- The 19th century saw a number of reported cases of multiple personalities which Rieber estimated would be close to 100.[17, 58]

Types of MPD: The primary identity, which often has the patient's given name, tends to be "passive, dependent, guilty and depressed" with other personalities or "alters" being more active, aggressive or hostile, and often containing more complete memories.[40] Most identities are of ordinary people, though fictional, mythical, celebrity and animal alters have also been reported.[18]

1. Co-Morbid Disorders

Most personality disorder cases have co-morbid mental disorders, with an average of 8 axis I and 4.5 axis II DSM diagnoses. The psychiatric history frequently contains multiple previous diagnoses of various disorders and treatment failures. The most common presenting complaint of MPD is depression, with headaches being a common neurological symptom.[23] Co-morbid disorders can include substance abuse, eating disorders, anxiety, posttraumatic stress disorder (PTSD) and personality disorders.[19, 22]

***2.* Borderline Personality Disorder(BPD)**

In 1993 a group of researchers reviewed both MPD and borderline personality disorder (BPD), concluding that MPD was an epiphenomenon of BPD, with no tests or clinical

description capable of distinguishing between the two.[20] Their conclusions about the empirical proof of MPD were echoed by a second group, who still believed the diagnosis existed, but while the knowledge to date MPD not justify MPD as a separate diagnosis, it also MPD not disprove its existence. The DSM-IV-TR states that acts of self-mutilation, impulsivity and rapid changes in interpersonal relationships "may warrant a concurrent diagnosis of BPD.[21]

3. Developmental Trauma

People diagnosed with MPD often report that they have experienced severe physical and sexual abuse, especially during early to mid-childhood, (although the accuracy of these reports has been disputed and others report an early loss, serious medical illness or other traumatic event.[37] They also report more historical psychological trauma than those diagnosed with any other mental illness. Severe sexual, physical, or psychological trauma in childhood has been proposed as an explanation for its development; awareness, memories and emotions of harmful actions or events caused by the trauma.[37]

MPD Change the Way A Person Experiences Life.

There are several main ways in which the psychological processes of Multiple personality disorder (MPD) change the way a person experiences living, including the following,[24-27]

- **Depersonalization.** This is a sense of being detached from one's body and is often referred to as an "out-of-body" experience.

- **Derealization.** This is the feeling that the world is not real or looking foggy or far away.[31]

- **Amnesia.** This is the failure to recall significant personal information that is so extensive it cannot be blamed on ordinary forgetfulness. There can also be micro-amnesias where the discussion engaged in is not remembered, or the content of a meaningful conversation is forgotten from one second to the next.

- **Identity confusion** or **identity alteration.** Both of these involve a sense of confusion about who a person is. An example of identity confusion is when a person sometimes feels a thrill while engaged in an activity (such as reckless driving, DUI, alcohol or drug abuse) which at other times would be revolting.

• It is now acknowledged that these dissociated states are not fully-mature personalities, but rather they represent a disjointed sense of identity. With the amnesia typically associated with MPD, different identity states remember different aspects of autobiographical information. There is usually a host personality within the individual, who identifies with the person's real name. Ironically, the host personality is usually unaware of the presence of other personalities.

• People living with DID/MPD may dissociate to avoid situations, people places and things (such as smells, music, colours, etc) that are associated or remind them of the childhood trauma that created the disorder.

• The experience of any intense emotion (anger, fear, joy and sadness) may result in a conscious or sub-conscious decision to avoid and "switch".

Causes of MPD: The severe dissociation that characterizes patients with MPD is currently understood to result from a set of causes[2, 28]

- An innate ability to dissociate easily.
- Repeated episodes of severe physical or sexual abuse in childhood.
- Lack of a supportive or comforting person to counteract abusive relative(s).
- Influence of other relatives with dissociative symptoms or disorders.

The primary cause of MPD appears to be severe and prolonged trauma experienced during childhood. This trauma can be associated with emotional, physical or sexual abuse, or some combination. One theory is that young children, faced with a routine of torture, sexual abuse or neglect, dissociate themselves from their trauma by creating separate identities or personality states.[8, 11] it is generally accepted that MPD results from extreme and repeated trauma that occurs during important periods of development during childhood. The trauma often involves severe emotional, physical or sexual abuse, but also might be linked to a natural disaster or war. An important early loss, such as the loss of a parent, also might be a factor in the development of MPD.[30, 31] In order to survive extreme stress, the person separates the thoughts, feelings and memories associated with traumatic experiences from their usual level of conscious awareness. The fact that MPD seems to run in families also suggests that there might be an inherited tendency to dissociate. MPD appears to be more common in women than in men. This might be due to the higher rate of sexual abuse in females.[28-31]

Symptoms: Symptoms of MPD are similar to those of several other physical and mental disorders, including substance abuse, seizure disorder and post-traumatic stress disorder.

Symptoms of MPD can include the following[32-34]

- Changing levels of functioning, from highly effective to nearly disabled
- Severe headaches or pain in other parts of the body
- Depersonalization (episodes of feeling disconnected or detached from one's body and thoughts)
- Derealization (perceiving the external environment as unreal)
- Depression or mood swings
- Unexplained changes in eating and sleeping patterns
- Anxiety, nervousness, or panic attacks
- Problems functioning sexually
- Suicide attempts or self-injury
- Substance abuse
- Amnesia (memory loss) or a sense of "lost time"
- Hallucinations (sensory experiences that are not real, such as hearing voices)

A person with MPD might repeatedly meet people who seem to know him or her, but whom he or she does not recognize.

Identity Disturbances in MPD: Some patients have histories of erratic performance in school or in their jobs caused by the emergence of alternate personalities during examinations or other stressful situations. Each alternate identity takes control one at a time, denying control to the others. Patients vary with regard to their alters' awareness of one another. One alter may not acknowledge the existence of others or it may criticize other alters. At times during therapy, one alter may allow another to take control.[25]

Table 1-various symptoms of MPD

1.Loss of time: "blackouts" unrelated to drugs, alcohol or neurological disorders	**2.**Inability to recall large portions of childhood
3.Spontaneous trance states: staring…even talking to oneself	**4.**Sudden and obvious changes in mood, behavior, even appearance
5.Objects or new clothes appear without knowing where they came from	6.Flashbacks or abreactions in which they seem to be reliving the traumatic experiences
7.Alcohol and drug abuse	8.Auditory and visual hallucinations
9.Somatic or physical complaints	10.Co-morbid Mental Health Problems

Headaches, up to severe migraines	Depression
Abdominal pain	Mood Swings
Chest pain	Anxiety
Vaginal or anal pain	Sleep disorders
Changes in vision	Eating disorders
Choking sensation	Suicidal ideation & self harm (cutting, burning)

Diagnosis

The *DSM-IV-TR* lists diagnostic criteria for identifying MPD and differentiating it from similar disorders[35-44]

- Traumatic stressor: The patient has been exposed to a catastrophic event involving actual or threatened death or injury, or a serious physical threat to him- or herself or others. During exposure to the trauma, the person's emotional response was marked by intense fear, feelings of helplessness, or horror.

- In general, stressors caused intentionally by human beings (genocide, rape, torture, abuse, etc.) are experienced as more traumatic than accidents, natural disasters, or "acts of God."

- The demonstration of two or more distinct identities or personality states in an individual. Each separate identity must have its own way of thinking about, perceiving, relating to and interacting with the environment and self.

- Two of the identities assume control of the patient's behavior, one at a time and repeatedly.

- Determination that the above symptoms are not due to drugs, alcohol or other substances and that they can't be attributed to any other general medical condition. It is also necessary to rule out fantasy play or imaginary friends when considering a **diagnosis** of MPD in a child.

- Proper diagnosis of MPD is complicated because some of the symptoms of MPD overlap with symptoms of other mental disorders. Misdiagnoses are common and include depression, schizophrenia, borderline personality disorder, somatization disorder, and panic disorder.

- When a doctor is evaluating a patient for MPD, he or she will first rule out physical conditions that sometimes produce amnesia, depersonalization, or derealization. These conditions include head injuries, brain disease (especially seizure disorders), side effects from medications, substance abuse or intoxication, AIDS dementia complex, or recent periods of extreme physical stress and sleeplessness. The physician also must consider whether the patient is malingering and/or offering fictitious complaints.

Nevertheless, it is important to recognize the *primary* symptoms of DID prior to discussing treatment modality. Dr. Gary Peterson (2003) of the University of South Florida outlines five of the primary dissociative symptoms that are indicative of DID.[38, 40, 44]

First, "inconsistent consciousness may be reflected in symptoms of fluctuating attention, such as trance states or 'black outs'"

Second, "autobiographical forgetfulness and fluctuations in access to knowledge" may be indicative of a disruption in memory processes in early childhood development.

Third, "fluctuating moods and behavior...may reflect difficulties in self-regulation".

Fourth, a "belief in alternate selves or imaginary friends…may reflect disorganization in the development of a cohesive self".

And **fifth**, "depersonalization and derealization may reflect a subjective sense of dissociation from normal body sensation and perception".

Peterson's model demonstrates how indications of detachment from the primary personality, and the emergence of sub personalities, contribute to a plausible diagnosis of DID.

Pathophysiology: Dissociation is a psycho physiologic process that alters a person's thoughts, feelings, or actions so that, for a time, certain information is not associated or integrated with other information as it normally. This process, which manifests along a continuum of severity, produces a range of clinical and behavioral phenomena involving alterations in memory and identity. In extreme cases, the process gives rise to a set of psychiatric syndromes known as dissociative disorders. Not all abused children develop a dissociation disorder; however, studies have shown that abused children demonstrate more dissociation than non abused children do.[39, 44]

He has proposed a 3 -factor theory to explain the genesis of MPD, as follows[44-46]

- Individuals have an innate potential to dissociate that is reflected in hypnotizability ratings.
- Traumatic experiences in early childhood may disturb personality development, leading to greater potential for psychodynamic dividedness.
- Individuals may be denied the chance to spontaneously recover because of continued emotional and/or social deprivation.

Complications of MPD

Dissociative disorders are also associated with major difficulties in personal relationships and at work. People with these conditions often aren't able to cope well with emotional or professional stress, and their dissociative reactions — from tuning out to disappearing — may worry loved ones and cause people at work to view them as unreliable. MPD is serious and chronic (ongoing), and can lead to problems with functioning and even disability.[47]

People with MPD also are at risk for the following[47-52]

- Suicidal thoughts and attempts
- Sexual dysfunction, including sexual compulsions or avoidance
- Alcoholism and drug use disorders
- Depression and anxiety disorders
- Post-traumatic stress disorder
- Personality disorders
- Sleep disorders, including nightmares, insomnia and sleepwalking
- Eating disorders
- Severe headaches.

Treatment of MPD

The goals of treatment for MPD are to relieve symptoms, to ensure the safety of the individual, and to "reconnect" the different identities into one well-functioning identity. Treatment also aims to help the person safely express and process painful memories, develop new coping and life skills, restore functioning, and improve relationships. Treatment is likely to include some combination of the following methods, [53, 54]

Psychotherapy: This kind of therapy for mental and emotional disorders uses psychological techniques designed to encourage communication of conflicts and insight into problems.

Cognitive therapy: This type of therapy focuses on changing dysfunctional thinking patterns.

Medication

There is no medication to treat the dissociative disorders themselves. However, a person with a dissociative disorder who also suffers from depression or anxiety might benefit from treatment with a medication such as an antidepressant or anti-anxiety medicine.

Family therapy

This kind of therapy helps to educate the family about the disorder and its causes, as well as to help family members recognize symptoms of a recurrence.

Creative therapies (art therapy, music therapy)

These therapies allow the patient to explore and express his or her thoughts and feelings in a safe and creative way.

Clinical hypnosis

This is a treatment technique that uses intense relaxation, concentration and focused attention to achieve an altered state of consciousness or awareness, allowing people to explore thoughts, feelings and memories they might have hidden from their conscious minds.

While not always necessary, hypnosis (or **hypnotherapy**) is a standard method of treatment for DID patients. Hypnosis may help patients recover repressed ideas and memories. Further, hypnosis can also be used to control problematic behaviors that many DID patients exhibit, such as self-mutilation, or eating disorders like **bulimia nervosa**. In the later stages of treatment, the therapist may use hypnosis to "fuse" the alters as part of the patient's personality integration processs.

Top Medications Used For the Treatment of Dissociative Identity

Medications have generally proven ineffective, except with the treatment of additional disorders such as anxiety, depression and post-traumatic stress disorder where the serotonin re-uptake anti-depressants have provided some relief. Selecting a specialist therapist in seeking treatment is vital.[53-56]

1. Antidepressant drugs: These include citalopram, venlafaxine, phenelzine, fluoxetine, and sertraline. These drugs help reduce depression in some dissociative identity disorder patients. Antidepressants must be taken only under expert guidance as some of them have several side effects. Any change in the patient’s behavior due to the effect of medication must be monitored consistently.

2. Depressants: Depressants are used to calm down certain dissociative identity disorder patients displaying violent and manic behavior. These drugs temporarily diminish hyperactivity of the brain. They are used to prevent seizures or respiratory disorders that can

be associated with a dissociative identity disorder. Examples of depressants include carisoprodol, atropine, benzodiazepines, and cyclobenzaprine.

3. Antipsychotic medication: These include chlorpromazine, aripiprazole, Risperdal®, Haldol®, and mellaril. These dissociative identity disorder drugs are used when the patient exhibits psychotic behavior. They work as mood stabilizers as well. Even if the dissociative identity patient is not diagnosed with psychosis, these drugs can be used to tranquilize and stabilize the mood. The drugs should be used strictly under the prescription and guidance of an expert physician.

4. Anxiety medication: These drugs are used for the treatment of dissociative identity patients who display excessive anxiety, or when anxiety is a trigger for dissociative identity disorder behavior. Anxiety can sometimes be an associated condition caused by dissociative identity problems.

5. Stimulants: These include midafinil, methylphenidate, caffeine, and dextroamphetamine. These are used as dissociative identity disorder drugs when the patient displays severe depression, or in cases where depression is a cause of dissociative identity problems. Stimulants improve the central nervous system's response and make the person alert, wakeful, and active. This medication should only be taken in recommended doses and on a physician's prescription. In addition, these medications are not suitable for some dissociative identity disorder patients.

Treatment Guidelines of ISSD: The International Society for the Study of Dissociation has prepared and published on its website detailed treatment guidelines for MPD. Their recommendations are quite extensive. They suggest three one-hour dynamic psychotherapy sessions per week with, if possible, support between sessions. They also recommend treatment for at least 2 years and for some up to 7 years. This means 200-1000 hours of therapy time, which has major cost implications.[4, 5]

Criminal Responsibility of MPD

Legal Issues

Within legal circles, MPD has been described as one of the most disputed psychiatric diagnoses and assessments. The number of court cases involving MPD has increased substantially since the 1990s and the diagnosis presents a variety of challenges for legal

systems. Courts must distinguish individuals who mimic symptoms of MPD for legal or social reasons. Within jurisprudence there are three significant problems.[57-59]

1. Individuals diagnosed with MPD may accuse others of abuse but lack objective evidence and base their accusations solely on regular or recovered memories.
2. There are a question regarding the civil and political rights of alters, particularly which alter can legally represent the person, sign a contract or vote.
3. Finally, individuals diagnosed with MPD who are accused of crimes may deny culpability due to the crime being committed by a different identity state.

In cases where not guilty by reason of insanity (NGRI) is used as a defense in a court, it is normally accompanied by one of three legal approaches — claiming a specific alter was in control when the crime was committed (and if that alter is considered insane), deciding whether all (or which) alters may be insane, or whether only the dominant personality meets the insanity standard. NGRI is rarely successful for individuals with MPD accused of committing crimes while in a dissociated states.60

(Short form used in this article: MPD: Multiple personality disorder)

CONCLUSION

Multiple Personality Disorder shows in many ways a very unusual presentation of mental illness. Because of its strangeness, many therapists even reject the whole idea of it. Over the last thirty years there has been a growing interest in this disorder and now we know much more about its causes, symptoms and treatability. There is still considerable controversy as to whether the alter personalities should be seen as attached entities as most of them claim to be. Spirit Release Techniques have been used successfully as a part of the treatment in published cases.

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