Dissociation & Multiple Personality Disorder

a Challenge for Psychosocial Nurses

By Linda L. Stafford, RN, PhD, CS

The number of individuals diagnosed with multiple personality disorder (MPD) has increased markedly over the last 15 years (Boor, 1982; Greaves, 1980; Putnam, 1986; Rivera, 1991). At the same time, this syndrome has been a subject of controversy, numerous case reports, and limited empirical data. Aldridge-Morris (1989), after conducting an extensive literature review of purported cases, concluded that there are insufficient reliable data about incidence and prevalence of this clinical entity.

Rather than argue for or against the validity of the diagnosis, this article describes behaviors associated with the phenomenon, explores the concept of dissociation, and suggests some guidelines for inpatient milieu management of clients manifesting these behaviors. Although therapists of all disciplines work with these individuals as outpatients, the majority of psychosocial nurses are likely to encounter persons labeled with MPD on an inpatient treatment unit. Thus, the examples given reflect a hospital setting.

The language used by those professionals who write about and treat MPD patients abounds with numerous terms, some of which may be marginally familiar to even sophisticated clinicians. Multiple personality disorder is one of the dissociative disorders in which two or more distinct personalities or personality states exist within a given individual (American Psychiatric Association, 1987). Additionally, at least two of these personalities recurrently take full control of the person's behavior.

These personalities may or may not be aware of each other. Various psychological or physiological differences have been observed among personalities in those manifesting this disorder. For example, some personalities may have different eyeglass prescriptions, different tolerance to alcohol, or may reveal variations in measured intelligence based on standardized tests. The legal personality, that is, the individual with the legal name of the body, is also referred to as the original or host personality. This personality may or may not be the same as the presenting personality, or the individual who enters therapy (Kluft, 1984).

The term "alter" describes other personalities residing within the body. These alter personalities may be helpful or destructive, the same or opposite sex of the host, the same or a different race, and may be of any age. Child and adolescent alters are the most common types and are usually the first to be discovered during therapy.

The term "dissociative" implies a separation, such as the separation of feelings from thoughts or memories that ordinarily accompany those feelings. Another way of phrasing this process would be a splitting off of some group of memories from the rest of an individual's identity, a classic example being that of amnesia. Thus, in MPD, one's identity is separated into several unique identities, known as alters.

A well-known example of such an occurrence was described in a book, The Three Faces of Eve (Thigpen, 1957), which was subsequently made into a popular movie. About 15 years later, another book was published about a young woman with MPD entitled Sybil (Schreiber, 1973), which was later produced as a movie for television. Both characters had been victims of various childhood traumas, most notably Sybil Dorsett (a pseudonym), who had endured years of physical and sexual abuse at the hands of a psychotic mother. Both movies may have created a theatrical mystique about MPD for the public as opposed to providing accurate

Linda L. Stafford, RN, PhD, CS, is Assistant Professor, University of Texas Health and Science Center at Houston, School of Nursing.

The author acknowledges Linda E. Pollack, PhD, RN, who reviewed an earlier draft of this article.

Address correspondence to Linda L. Stafford, RN, PhD, CS, 1100 Holcombe, Houston, TX 77030.
Multiple personality disorder is one of the dissociative disorders in which two or more distinct personalities or personality states exist within a given individual.
information. Another dramatic case study, When Rabbit Howls (Chase, 1987) was supposedly autobiographical. This book described the author's childhood sexual abuse by a despicable stepfather.

Review of Literature

Paracelsus, credited by Bliss (1980) as being the first to describe a case of MPD, wrote in 1646 about a woman who was amnesic for an alter personality who had stolen her money. The most publicized early case, however, was that of Mary Reynolds, popularized by Harper's New Monthly Magazine in 1860 (Carlson, 1984).

From 1880 to about 1920 there was heightened interest in multiple personality (Ellenberg, 1970; Sutcliffe, 1962). Dissociation and multiple personality became topics of great interest for many noted physicians, psychologists, and philosophers of the era. However, from 1920 to 1970 there was an apparent decline of interest and also a decline in the number of cases reported (Greaves, 1980). One factor that may have contributed to the decline of MPD cases during this period is thought by some to be the burgeoning number of patients diagnosed as having schizophrenia (Rosenbaum, 1980). Some theorists believe that many MPD cases were, in fact, incorrectly labeled as schizophrenia. However, as the 1970s progressed, a plethora of MPD reports once again appeared in the psychiatric literature, serving to refocus attention to this classification.

The nursing literature continues to be rather sparse on the topic of MPD, as noted by Drew (1987) in an article published in Archives of Psychiatric Nursing. The same issue featured companion articles on MPD. Lego (1987) described an interpersonal approach to etiology, treatment, and nursing interventions; Anderson and Ross (1987) explored various treatment strategies for MPD clients.

Research on multiple personality is relatively new and has taken many different directions. A study by Condon and colleagues (1969) attempted to analyze, frame by frame, a 30-minute film of “Eve” made by Thigpen and Cleckley to search for variations in eye movement that occurred as the subject switched alters; that is, changed back and forth from “Eve White” to “Eve Black” to “Jane.” Other studies have attempted to establish a relationship between MPD and severe headaches, as this complaint is common in these individuals and viewed as suggestive of an organic component in the syndrome. Additionally, EEG studies have been conducted to look for differences in activity that would correlate with different personality states in MPD clients (Spanos, 1985).

Yank (1991) examined handwriting characteristics of 11 women diagnosed with MPD with the use of electronic calipers under magnification. Analysis of each client’s handwriting determined that MPD subjects showed significantly more variability on samples produced by different alters than would be expected from different samples ordinarily produced by the same person. Although investigators continue to examine physiological aspects of the syndrome, research to date has yielded no reliable data on a consistent basis (Aldridge-Morris, 1989).

The Role of Dissociation in MPD

Some definitions of dissociation focus on a continuum that ranges from minor dissociations of everyday life (eg, daydreaming) to the pathological forms (eg, multiple personality) (Bernstein, 1986). Other definitions are mainly concerned with deciding when an individual’s sense of identity, consciousness, or behavior is sufficiently fragmented to represent an abnormal or pathological process (Putnam, 1989). Dissociation has also been defined as a complex psychophysiological process containing psychodynamic triggers that can produce an alteration in the individual’s consciousness (Putnam, 1989; West, 1967). At this time, thoughts, feelings, and actions are supposedly not integrated into the individual’s memory or awareness in the usual way. Two characteristics are found in the most extreme types of dissociative experiences: a disturbance in the individual’s sense of identity and a disturbance of memory.

Although MPD clients do not usually present initially with complaints of dissociation, all individuals with this syndrome are plagued with a variety of dissociative symptoms (Putnam, 1989). The most common of these symptoms involves inconsistencies in accounts of elapsed time or frank amnesia (Coons, 1984). Results from a National Institute of Mental Health survey study indicated that the most commonly reported symptoms of dissociation were amnesia, fugue episodes, feelings of depersonalization, and sleepwalking (Putnam, 1986).

The vast majority of MPD clients report histories of severe childhood trauma, particularly physical, sexual, and ritual cult abuse (Boor, 1982). Additionally, most reviews and case collections of MPD in the last decade indicate that this syndrome has its origins in childhood, although it is usually not diagnosed until adulthood. In most reported cases, the first dissociative episode is thought to occur at a very young age. For example, a victim of incest by her stepfather might describe how a part of her would “go to sleep” when the perpetrator would come into her room at night. Klut (1984), after working with many MPD clients, maintains that the first alternate personalities (alters) emerge as early as 5 years of age or younger.

Braun and Sach’s (1985) 3-P model of MPD conceptualizes the etiology as that of predisposition, precipitation, and perpetuation. Here, predisposition is defined by the biopsychological capacity...
to dissociate, combined with the child’s exposure to a severely abusive environment. Precipitation refers to an overwhelmingly traumatic event that initiates the first use of dissociation as a coping mechanism to escape an intolerable situation. Perpetuation occurs when the continuing abusive phenomena link subsequent dissociative episodes with a common affective theme, eventually resulting in separate memories for each. The individual, over time, begins to experience discrete life histories for each set of memories.

Another way of viewing dissociation is referred to as the BASK model, developed by Braun (1988), who conceptualizes dissociation primarily as a discontinuity in the memory process. In this model, behaviors, affects, sensations, and knowledge (BASK) related to the precipitating trauma have been separated from consciousness and walled off by a barrier of amnesia. When the amnesic barriers fall, either spontaneously or through some therapeutic direction, such as hypnosis, the client remembers events not only on a cognitive level, but also on an emotional, sensory, and behavioral level. Thus, the individual experiences an abreaction.

Clinical Manifestation of MPD
Although MPD is thought to develop in childhood, the symptoms often remain unrecognized for many years. Most cases are diagnosed when patients are 20 to 50 years of age, and women outnumber men in a ratio of about 5 to 1 (Kluft, 1985). One may be led to suspect MPD by some of the following signs and symptoms:

- A history of several medical and psychiatric diagnoses;
- Inconsistencies in accounts of elapsed time;
- Inconsistencies in physical behaviors, such as switching right or left handedness, voice changes, or marked differences in clothing and hair styles on different occasions;
- Psychophysiological complaints, eg, severe headaches, chest pain, or a fluctuation in pain threshold;
- Experiencing of voices inside of the head talking to one another or to the patient; and

- An individual referring to herself as “we” rather than “I.”

Case Example
Karen was an attractive 32-year-old interior decorator who had functioned well, enjoying an increasingly successful career, until about 2 years ago. She first sought the help of a psychiatrist for vague complaints of depression and feelings that she might be “going crazy.” Treatment with antidepressants was unsuccessful and she abruptly terminated her sessions with the psychiatrist. Frequent periods of “forgetfulness” and confusion began to plague Karen in that she would miss appointments she had set up with clients and would sometimes find that the date was 2 or 3 days later than she had thought. A precipitating event for hospitalization appeared to be the murder of a young woman tenant in the same apartment building where Karen barely knew. Much media coverage of this murder turned up evidence indicating that the victim had been trying to escape a cult in which she had previously been involved.

Although claiming to know nothing of cults and their related rituals, Karen believed that this same cult was also plotting to kill her. She began to dream frequently of hooded intruders and was often awakened by nightmares in which she saw herself covered with blood that was not her own. She also began to experience voices described as being inside her head that told her “to make the blood come.”

Feeling overwhelmed and having thoughts of suicide, Karen discovered that she was bleeding from a laceration on one arm. Having no memory of how she had been injured, she drove herself to a nearby hospital. In the emergency room she gave the impression of being highly agitated. However, a short time later she was perfectly composed and apologized several times for “Karen’s hysterical behavior.” She also voluntarily signed herself in for a psychiatric evaluation, insisting that her name was Karina. After an initial assessment, it was the opinion of the admitting psychiatrist that Karen was manifesting symptoms of MPD.

After several months of hospitalization with intensive psychotherapy, Karen learned a number of details of her life that had heretofore been totally inaccessible to her. Although always believing she was completely alone in the world with no living relatives, she experienced repeated memories of a couple she had lived with who were physically abusive and who had given her away to a group of people. More memories emerged, such as being put in a cage, buried in the ground in a box, and being forced on occasion to participate in bizarre sexual acts and ritual sacrifices involving both animals and humans.

A variety of techniques, including hypnosis, were employed to assist in recall of early memories to produce abstractions. In this context, the purpose of invoking abstractions was to provide Karen with the opportunity to experience the feelings associated with the traumatic events, but this time in a setting that felt safe both physically and emotionally.

Clinical Interventions in MPD
In this example, the patient was a victim of repeated abuse, including cult activities, over an extended period. The severity of the trauma set the stage for the fragmentation of her personality into more than 40 different alters. Karen’s original, or “birth,” personality did not emerge until much of the early work in therapy had been accomplished. The host personality that sought treatment presented itself as self-effacing, passive, and confused much of the time.

This client showed slow but fairly consistent improvement. To address self-destructive behaviors in the hospital, a
behavioral contract was negotiated with the nursing staff and Karen. The terms of the contract were concrete and specific, stating, "If I feel at any time that someone is going to try to hurt the body, I will immediately notify the staff." This contract was negotiated with the entire personality system, a provision being that all alter personalities would be held equally accountable.

At the time, it was uncertain how many child alters were in existence, so Karen was asked to explain the contract to the young alters in a way that they could understand. This aspect of milieu treatment was fairly successful in that most of the self-mutilative behavior ceased and Karen expressed confidence that she was gaining even a small measure of control over her dissociative episodes. This focus on mastery and client participation is probably critical to offset frequent experiences of lack of control and shattered security.

Psychotherapy with an MPD client is an arduous process, requiring skill, patience, and an extended period. However, an equally challenging task is management of the inpatient milieu so that it is truly therapeutic for those clients requiring hospitalization. This undertaking poses a challenge to psychosocial nurses, both in general psychiatric units and in specialized treatment units for MPD patients. Indeed, a literature search failed to yield any empirical studies that dealt specifically with milieu management of clients with MPD. Some clinicians have suggested that an understanding of borderline psychopathology is essential, and that the borderline personality is the foundation for development of MPD (Benner, 1984). However, the extent to which MPD patients exhibit borderline behavior may vary considerably.

Clients with MPD have usually been conditioned by authority figures who were extremely inconsistent. These individuals may have been both rigid and unpredictable, making it impossible for the client to develop a sense of trust. Thus, MPD patients may be very distrustful of staff and may try to manipulate nurses into behaviors that prove their unreliability. Thus, consistency in the milieu is very important—particularly in conveying a caring, nonpunitive, and predictable environment. Indeed, some clients will set up classic double-bind situations so that nurses will look uncaring or insincere. For example, if nurses wake a patient for breakfast, they may be accused of being too authoritarian; if they let the patient sleep, nurses may be accused of not caring whether or not the client gets enough to eat. In such a situation, a matter-of-fact, nondefensive manner has been observed to be effective.

Another problem that arises with many MPD clients is self-mutilative or violent behaviors that may occur almost instantaneously. It will not always be clear to the observer what precipitated the outburst, although sometimes environmental cues will serve as triggers for switching alters. One client often became agitated at the change of shifts, banging her head against the wall until staff physically intervened. Seeing groups of staff arriving and departing triggered flashbacks of her original family leaving her at the home of relatives where she had repeatedly been sexually abused. Immediate and decisive action is critical when violence to the self or others is imminent (Fortinash, 1991). In some instances, seclusion or restraints may be necessary, as well as administering a p.r.n. medication.

Successes, however small, contribute to the development of a therapeutic alliance, increase the level of trust, and set the stage for positive learning experiences. They will likely need frequent supervision and consultation when working with these individuals. Trust building must be initiated on admission to allow the host personality to develop rapport with the staff. Much of the individual psychotherapy consists of resolution of the previously repressed trauma and development of new coping skills. Creation of a single, integrated personality is rarely possible and probably unrealistic as a treatment goal. Much is still to be learned about the phenomenology of this syndrome. It is hoped that psychosocial nurses and other mental health professionals will continue to expand their knowledge base of the dissociative disorders and of MPD in particular.

References


Journal of Psychosocial Nursing 1993, Vol. 31, No. 1
MPD KEY POINTS


1. Multiple personality disorder (MPD) is a dissociative disorder in which two or more distinct personality states exist within an individual. At least two of these personalities recurrently take full control of the person’s behavior.

   Most MPD clients report histories of severe childhood trauma, particularly physical, sexual, and ritual cult abuse. MPD most likely originates in childhood, but is not usually diagnosed until adulthood. In most reported cases, the first dissociative episode is thought to have occurred at a very young age.

   Signs and symptoms that may suggest MPD include a history of medical and psychiatric diagnoses; inconsistencies in accounts of elapsed time and physical behaviors; psychophysiological complaints; experiencing voices inside the head; and an individual referring to herself as “we” instead of “I.”

2. 

3. 

personality. *Arch Gen Psychiatry* 1980; 37:1383-1385.


Yank, J.R. Handwriting variations in individuals with MPD. *Dissociation* 1991; 4:2-12.