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NURSES RESEARCH PUBLICATION MULTIPLE PERSONALITY

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COURSE OBJECTIVES

Upon completion of this course, the participant will be able to:

1) Identify the events that lead to a dissociative disorder.
2) Define dissociation.
3) Explain the dynamics of dissociation.
4) Describe the continuum of dissociation.
5) Explain the influences that manifest Multiple Personality Disorder, as described in models by Kluft and Braun.
6) Explain the phenomenon of the personality system and the relationships the personalities have with each other and the host.
7) Describe the most common personalities.
8) Explain the difficulties in making the diagnosis.
9) Identify tools that assist in making the diagnosis.
10) Describe common presentations of Multiple Personality Disorder.
11) Describe appropriate methods of treatment for Multiple Personality Disorder, including outpatient and inpatient treatment, and pharmacological concerns.
12) Explain the role of nursing staff with the Multiple Personality Disorder patient in a hospital setting; specifically how to insure patient success in treatment and provide for needs of staff.
13) Describe specific techniques for managing a dissociative crisis.

INTRODUCTION

Since the first exploration of the phenomenon of Multiple Personality Disorder some hundred years ago, the diagnosis has been the recipient of much confusion and skepticism, Because its presentation can be so dramatic and the precipitating trauma so humanly unacceptable, it was passed off as the hysterical behavior of overwrought or spoiled women, However, with the attention in recent years to the issue of child abuse, Multiple Personality Disorder has gained acceptance as a valid psychiatric diagnosis. Once considered rare, the reported incidence has increased steadily since 1980. It occurs in 1.2% of the general psychiatric population (Steele, 1989(, making it about as common as schizophrenia.

Dissociative Disorders (DD), specifically Multiple Personality Disorder (MPD), have received much attention in the past decade, though they are not new phenomena. In fact, these disorders were among the first psychiatric conditions to be scientifically investigated by the nineteenth century pioneers of psychiatric medicine (Putnam, 1991). However, in the twentieth century the work of such pioneers was largely set aside and forgotten as Freud introduced his psychoanalytic model which substituted the idea of repression for dissociation in dynamic formulations.

MPD remains highly controversial among psychiatric professionals. The reality of the disorder is often challenged. Putnam feels "this distorts the scientific process and places an extra burden of proof on MPD that is not demanded of other psychiatric disorders." MPD and DD have met all the requirements expected of other psychiatric diagnoses, and Putnam maintains that "by this standard, MPD and the dissociative disorders are as "real" as any other psychiatric condition."

However, the 1970's and 1980's saw renewed scientific interest in the disorder due to more objective case studies and more sophisticated investigations, Also, awareness and acceptance in the past two decades of the prevalence and impact of child abuse, posttraumatic stress disorder and the importance of psychosocial stress as the underlying causes for dissociative disorder has led to their greater validation.

Multiple Personality Disorder, once considered a rarity and a curiosity, is now being diagnosed with increasing frequency. It is a difficult disorder to diagnose due to the multiple co-existing symptoms and disorders, and the secrecy which keeps its victims from seeking help. Although the disorder wreaks havoc in the lives of its victims, they will generally do anything possible not to be found out. The fear of appearing crazy or of sustaining punishment from the childhood abuser often keeps the MPD patient from disclosing information which would make diagnosis possible, lead to an appropriate course of treatment and eventual healing.

Despite the patient's efforts to hide the traumatic past and conceal the chaotic internal life from others, the knowledgeable professional can see the signs and symptoms of MPD and learn to work effectively with them.

Nurses play an important role in the treatment of MPD patients in a hospital setting. These patients can be particularly challenging to a nursing staff. This course attempts to assist nurses in their work with MPD patients by providing information about the disorder and techniques to ensure that patient and staff receive what they need to proceed in this most arduous of treatment courses.

CONTINUUM OF DISSOCIATION

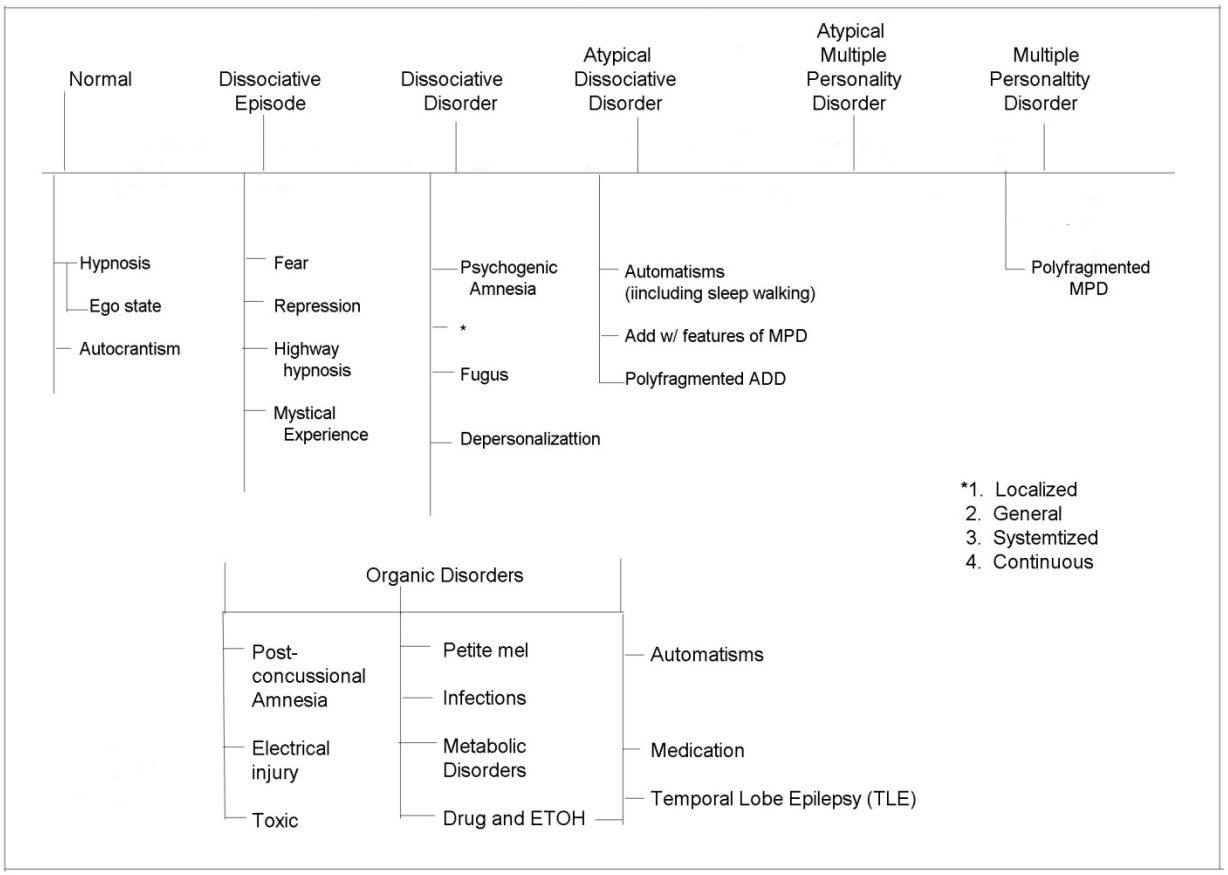


FIGURE 1. The continuum of dissociation. Add = atypical dissociative disorder. MPD = multiple personality disorder. ETOH = alcohol. Note. From "The BASK Model of Dissociation" by B.G. Braun, 1988, *Dissociation*, 1, p.12. Copyright 1988 by *Dissociation.* Reprinted by permission.

ETIOLOGY

In 1889 Pierre Janet, a French psychiatrist, wrote that "certain happenings would leave indelible and distressing memories – memories to which the sufferer was continually returning and by which he was tormented by day and by night." (Van der Kolk, 1989) Janet understood over 100 years ago what lay at the very core of dissociation. Dissociation is defined as a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness. Freud felt that dissociation was a process of defense which would remove threatening or overwhelming thoughts from a person's awareness.

This same idea is supported by today's professionals. Dissociation is seen as a coping mechanism and develops when normal coping mechanisms are depleted or over-taxed. In this weakened state the individual withdraws consciousness, or dissociates from the event, while the brain then encodes the event in a different fashion so that the intense shock can be split off and thereby not completely experienced by the individual.

The most extreme level of dissociation is called Multiple Personality Disorder, or MPD. Multiple Personality Disorder is described as chronic dissociative posttraumatic stress psychopathology (Braun, 1990). It is the result of trauma which is far greater than normal stress and surpasses the individual's ability to cope. In these cases the individual is so traumatized that the young developing mind fragments, or splits off, into different selves. The psyche creates a separate consciousness, or personality, in which it absorbs the overwhelming trauma and stores the information. Often there are several of these other personalities. Each of the personalities then responds to the traumatic information in a different way. With the information about the trauma split up, the child is then better able to cope with it. It is the same idea as sharing a problem with friends. Once the burden is shared, it becomes easier to bear.

MPD begins in childhood, between the ages of two and eight. Because the very nature of children's dependence upon adults renders these incapable of "fight or flight" they will instead flee inward, thereby abandoning the sense of involvement or responsibility for the situation. Otherwise, the feelings of guilt and terror would be overwhelming. Without this coping mechanism, the child might perish under the pressure, either through suicide or psychotic break.

Childhood physical or sexual abuse is commonly found in the history of someone with MPD. It has been found that 97-98% of MPD's have experienced child abuse in some form – physical, sexual, or psychological mistreatment and neglect. (Talbott, 1988).

Approximately two percent of MPD's report no incidence of child abuse, but have experienced a trauma often perceived as life-threatening, such as near drowning or witnessing the violent death of another person. (Steele, 1989).

The traumas could be a single event, such as a case of rape, although the chronic dissociation seen in MPPD patients is, in most cases, the result of repeated severe or inhuman abuse, rather than an isolated experience (Steele, 1989).

The child is usually from an environment where not only has trauma occurred, but also where the necessary protection to prevent the trauma re-occurring, or the nurturing to enable the child to resolve the trauma is nonexistent.

Though the disorder begins in childhood it may remain undiagnosed for many years. Not all individuals with MPS are as obvious as Hollywood would have us believe. Sometimes the switching, or changing to other personalities, is very subtle and can only be detected by those who know the person very well. Because of amnestic barriers the individual may be unaware of the presence of other personalities. It may only come to the person's attention after others have

remarked about unusual behavior. Often people with MPD will find articles among their personal belongings that seem to belong to someone else. This may lead them to think they are going crazy.

The person with MPD may feel that something is terribly wrong, but have no idea about the multiplicity. This is a condition which can be hidden for long periods of time and only show itself during stressful situations, such as problems with work or relationships.

Females represent 75 – 90% of reported cases. This is most likely duae to the different manner in which men and women respond to emotional trauma. Women tend to act out in harmful ways against themselves and find their way into treatment after self-mutilation or suicide attempts. Self-mutilation includes such behavior as cutting superficially without suicide intent, burning the skin with a cigarette, and banging the head against a wall. Men, on the other hand, have been found more likely to respond to psychic paid by committing violent crimes against others and ending up in the criminal justice system. (Talbott, 1988).

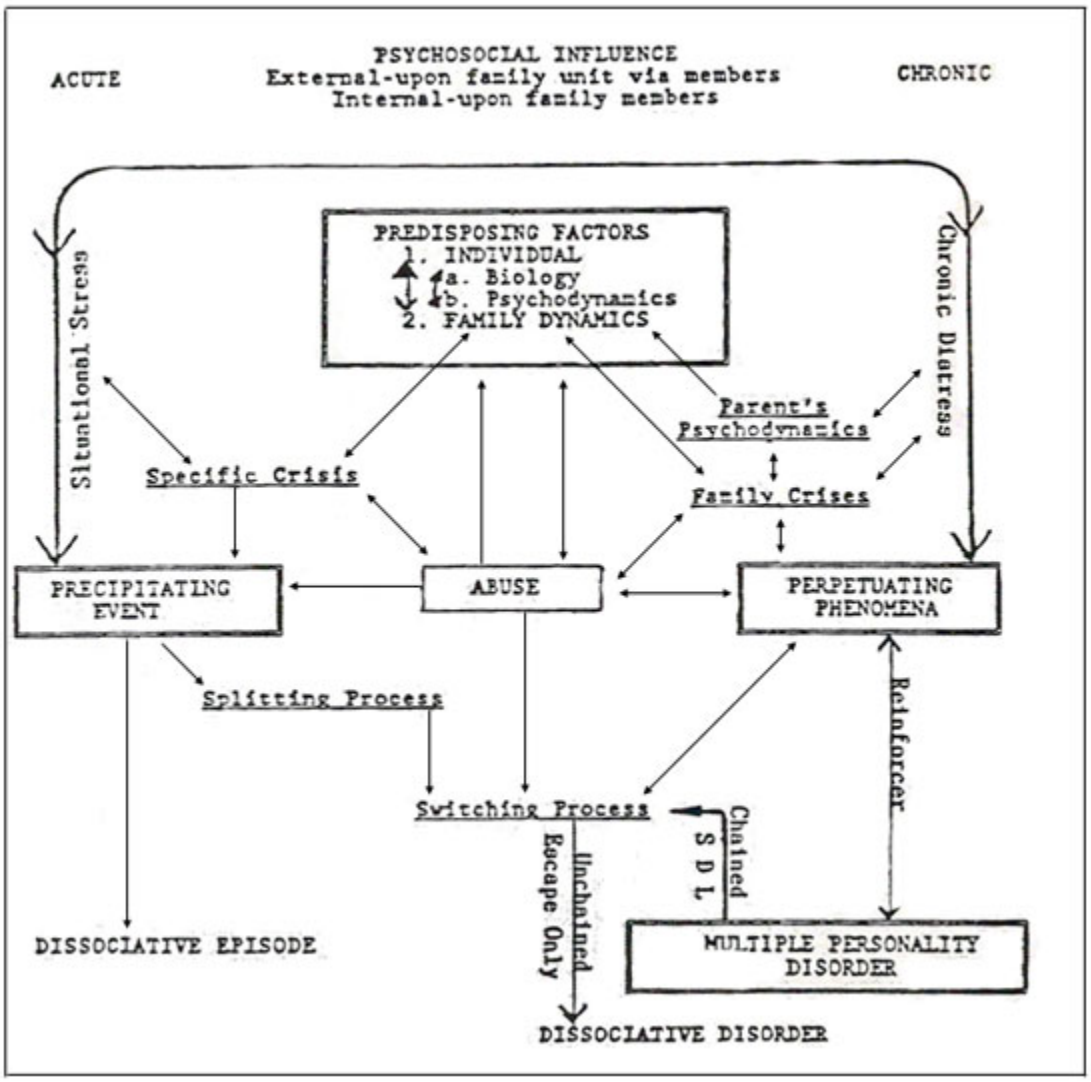


FIGURE 2 The 3-P model of multiple personality disorder (Braun & Saches, 1985) SDL = state dependent learning. Note. From Treatment of Multiple Personality Disorder (p.6) by B.G. Braun (Ed.) 1986, Washington, DC: American Psychiatric Press. Copyright 1986 by American Psychiatric Press. Printed by permission.

Etiological Models

Kluft offers the following etiological model. He suggests that these four factors must be present in order for an individual to develop MPD:

Factor 1:	The individual possesses a predisposition for dissociation, seen by a high degree of hypnotizability.
Factor 11:	Normally adaptive capacities are overwhelmed by traumatic events, such as severe child abuse, so that the organism dissociates as a defense mechanism.
Factor III:	The unique combination of psychological substrates occurring in each individual provides the building materials for specific alternate personality formations. These shaping influences include self=object constancy, cognitive structures of separateness, developmental lines, and normal dissociative phenomena.
Factor IV:	An absence of nurturing, soothing, and restorative experiences which might enable the child to recover from the trauma. Also, the failre of significant others to protect the child from further trauma. The trauma is repeated over and over again. (Steele, 1989)

Braun and Sachs suggest the 3-P model as an explanation of the development of MPD. It is a similar model to Kluft's in etiological framework. (See Figure 1) This model consists of predisposition, precipitation, and perpetuation:

> *Predisposition* – The biopsychological capacity to disassociate and the child's exposure to an environment in which server abuse was meted out unpredictably by parents and other caregivers repeatedly.
>
> *Precipitation* – An overwhelmingly traumatic event that indicates the first use of dissociation as an escape or coping mechanism.
>
> *Perpetuation* – The continuing abusive phenomena link subsequent dissociative episodes with a common affective theme, eventually resulting in separate memories for each. Over time, the patient begins to experience discrete life histories for each set of memories. (Braun, 1990)

Kluft's and Braun's model are similar. The difference is in Kluft's specific mention of the absence of a nurturing environment where the child might have the opportunity to heal. This is implied in Braun's "Perpetuation".

Essentially, the literature all points toward a common theme in the etiological background of patients with MPD. This is an individual with a predisposition to dissociate, who grows up in a highly abusive environment where there is no opportunity for respite or escape, and the abuse is ongoing. Braun reports that an estimated prevalence of MPD in the United States is 0.1% (Braun, 1990). MPD has also been found to span generations (Kluft, 1991b).

DYNAMICS OF DISSOCIATION

Multiple Personality Disorder is classified in the DSM-III-R as a dissociative disorder. Braun defines dissociation as the separation of an idea or thought process from the main stream of consciousness (Braun, 1990). In the DSM-III-R dissociation is defined as a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness. Dissociation is the primary defensive structure at the core of MPD. There are different levels of dissociation, which are generally dictated by the type or degree of trauma the individual has undergone. The various dissociative phenomena can also be seen in combination, particularly in Multiple Personality Disorder, where other dissociative disorders present as symptoms of MPD.

Dissociation has been seen more and more commonly in the past twenty years as patients' have come forward with memories of childhood sexual abuse. This traumatic material has generally been forgotten until a stressful adult experience, such as an intimate relationship, sexual harassment at work, or the death of the abuser, triggers the memory. It is difficult to understand how one might forget such childhood experiences, and naturally this leads to skeptics questioning the validity of such experiences. However, with a clear understanding of dissociative phenomena, one can only appreciate the wonderful protective powers of the human brain.

Dissociation is a defense mechanism created to protect the individual against noxious trauma. It is the individual's attempt to manage intolerable affect by walling off the traumatic material from consciousness and by simultaneously creating a separate consciousness in which the trauma can be filed. The ego screens traumatic stimulation from the field of consciousness in order to prevent sensory overload.

Post traumatic stress disorder (PTSD) is a diagnosis given to victims of childhood abuse, and is directly related to the phenomenon of dissociation. Individuals suffering from PTSD have experienced trauma outside the range of usual human experiences, which would produce severe psycho physiological stress. This stress then triggers an altered state of consciousness, which is a hypnoidal dissociative state. Multiple personalities can be viewed as altered states of consciousness produced as a severe and chronic manifestation of PTSD. (Steele, 1989)

Dissociation exists along a continuum starting with lower levels of dysfunction and going to higher and more disabling levels. Dissociation is something most of use on a daily basis.

Much of our consciousness is outside our awareness as we go about our daily lives. Purely as an example, we can look at daydreaming as a low level dissociation. We all daydream and there is nothing wrong or dysfunctional about it. But this is a good way to begin to understand what dissociation is all about. Daydreaming takes us momentarily away from the present. When we snap out of a daydream we realize things have gone on around us without our being consciously aware. The teacher is now talking about another subject, someone has left the room, friends are laughing at the punch line of a joke we only remember hearing the beginning of. The daydream helped us to momentarily escape. This is exactly what happens when dissociation occurs.

Everyone dissociates to some degree at certain times. On a normal level daydreaming, "spacing out" or forgetting something does not affect our overall function in life, is not pathological and cannot be attributed to a traumatic past event. This type of dissociation is normal and is only used as an example to better understand the process of dissociation.

Moving along the continuum from daydreaming, a non-pathological behavior, we find the pathological dissociative disorders which are identified in the DSM-III-R. (See Figure 2)

These include depersonalization, amnesia, fugue, and multiple personality disorder (MPD). The severity or complicity of dissociation is dependent upon certain factors which relate to the abuse. The age of the individual during the time of the traumatic event is an important variable. The younger the child, the more severe the disorder. The frequency of the abuse and the amount of damage incurred are important variables. The degree of dissociation will depend upon who the abuser is; abuse by a family member is more traumatic than abuse by someone outside the family circle.

DEPERSONALIZATION

Depersonalization is the experience of feeling detached from oneself, as if one is an outside observer to one's own behavior. This person tends to have a chronic sense of discomfort with herself, feeling estranged from her own body or thoughts.

This is a surprisingly common disorder, occurring in 30 to 70& of young adults. It is the third most common complaint among the psychiatric population. (Talbott, 1988) These patients often fear they are going insane.

An example of this would be a woman who was the victim of childhood incest and as an adult must depersonalize her sexual experiences with her spouse. She will subconsciously separate from her body in order to avoid the painful memories of the abusive past which are triggered by her adult sexual involvement. She may not be unaware of this behavior until her partner makes a comment like, "You seem a million miles away." Or she may actually have the sensation of separating from her body and watching from afar.

Friction in this marriage might lead the woman into therapy where she would subsequently discover the traumatic events from which she has escaped all these years.

The child victimized by sexual abuse will employ depersonalization as a defense

mechanism against the trauma. She will dissociate by separating from her body in order to continue living through the terrible ordeal which is out of her control. In order for the child to remain living in her family she must create a separate self which commits the incestuous act. She is somehow able to protect a part of her psyche with the thinking, "This is not happening to me but to someone else; I am not guilty because I am not I." This ability of the child to fragment in order to absorb the trauma is the only mechanism preventing complete emotional collapse.

The following is the diagnostic criteria for Depersonalization Disorder taken from the DSM-III-R:

A. Persistent or recurrent experiences of depersonalization as indicated by either (1) or (2):

   (1) An experience of feeling detached from, and as if one is an outside observer of, one's mental processes or body.
   (2) An experience of feeling like an automation or as if in a dream

B. During the depersonalization experience, reality testing remains intact.

C. The depersonalization is sufficiently severe and persistent to cause marked distress.

D. The depersonalization experience is the predominant disturbance and is not a symptom of another disorder, such as Schizophrenia, Panic Disorder, or Agoraphobia without history of Panic Disorder but with limited symptom attacks of depersonalization, or temporal lobe epilepsy.

The DSM-III-R distinguishes between the symptom of depersonalization and Depersonalization Disorder. Depersonalization can be seen as a symptom in Schizophrenia, Mood Disorders, Organic Mental Disorders (especially Intoxication and Withdrawal), Anxiety Disorders, Personality Disorders, and Epilepsy. Depersonalization Disorder is only diagnosed when the episodes of depersonalization are recurrent and persistent, and are severe enough to cause marked social or occupational impairment.

PSYCHOGENIC AMENSIA

The amnesia begins suddenly and is usually the result of a severely stressful situation. Such a stress might involve the threat of physical injury or death, the unacceptability of an impulsive act, such as an extramarital affair, or an intolerable life situation, such as abandonment by one's spouse. During the episode the person appears perplexed, disoriented and may wander aimlessly. The amnestic episode usually ends abruptly, with full recovery and rare reoccurrences. The individual is usually aware of the disturbance in recall upon recovery.

This, again, is to be differentiated from amnesia as a symptom, such as one might see in a female patient who was the victim of childhood incest and who suddenly brings forth memories of the forgotten abuse in later adulthood.

The following is the diagnostic criteria for Psychogenic Amnesia taken from the DSM-III-R:

A. The predominant disturbance is an episode of sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

B. The disturbance is not due to Multiple Personality Disorder or to an Organic Mental Disorder (e.g., blackouts during Alcohol Intoxication).

There are four types of disturbance in recall:

1) Localized amnesia – Failure to recall all events occurring during a circumscribed period of time, usually the first few hours following a profoundly disturbing event. An example of this is the survivor of a car accident that killed all of his immediate family. He does not recall anything that happened from the time of the accident until two days later. This is the most common type of amnesia.

2) Selective amnesia – Failure to recall some, but not all, of the events occurring during a circumscribed period of time. In the above example, the uninjured survivor recalls making the funeral arrangements, but not concurrent discussions with family members.

3) Generalized amnesia – Failure of recall encompasses the person's entire life.

4) Continuous amnesia – The individual cannot recall events subsequent to a specific time up to and including the present.

PSYCHOGENIC FUGUE

As in Psychogenic Amnesia, Psychogenic Fugue is caused by an unusually stressful event. It is generally seen during wartime or after a natural disaster. The travel and behavior present as more purposeful than the confused wandering of Psychogenic Amnesia. Following recovery, there is no recollection of the events that took place during the fugue.

Diagnostic criteria for Psychogenic Fugue taken from the DSM-III-R:

A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.

B. Assumption of a new identity (partial or complete).

C. The disturbance is not due to Multiple Personality Disorder or to an Organic Mental Disorder (e.g., partial complex seizures in temporal lobe epilepsy).

MULTIPLE PERSONALITY DISORDER

On the continuum of dissociative disorders, MPD is at the furthest extreme, is the most complex and denotes the most heinous of abuse cases. These patients are often survivors of cult abuse where satanic rituals are practiced, involving cannibalism, torture, group sex, and death threats. If not due to cult abuse, the victim has been physically and sexually abused repeatedly, generally starting at a very young age. Tortuous physical abuse, punishment and possibly death threats are present.

Diagnostic criteria for Multiple Personality Disorder taken from the DSM-III-R:

A. The existence within the person of two or more distinct personalities or personalities states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

In an explanation of personality and personality states, DSM-III-R defines personality as a relatively enduring pattern of perceiving, relating to, and thinking about the environment and one's self that is exhibited in a wide range of important social and personal contexts. Personality states differ only in that the pattern is not exhibited in a wide a range of contexts.

DISSOCIATIVE DISORDER NOT OTHERWISE SPECIFIED (NOS)

This would include disorders where the predominant feature is a dissociative symptom, but it does not meet the criteria for a specific Dissociative Disorder.

The DSM-III-R gives the following examples of Dissociative Disorder NOS:

1) Ganser's syndrome: the giving of "approximate answers" to questions, commonly associated with other symptoms such as amnesia, disorientation, perceptual disturbances, fugue, and conversion symptoms;

2) Cases in which there is more than one personality state capable of assuming executive control of the individual, but not more than one personality state is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete executive control;

3) Trance states, i.e., altered states of consciousness with markedly diminished or selectively focused responsiveness to environmental stimuli. In children this may occur following physical abuse or trauma;

4) Derealization unaccompanied by depersonalization;

5) Dissociated states that may occur in people who have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reforms, or indoctrination while the captive of terrorists or cultists);

6) Cases in which sudden, unexpected travel and organized, purposeful behavior with inability to recall one's past are not accompanied by the assumption of a new identity, partial or complete.

THE PERSONALITY SYSTEM

The average number of personalities for a person with MPD ranged from eight to thirteen. However, there can be many more; some cases have reported up to 100 or more personalities. The personalities may be referred to as alter personalities, alternates, or alters. Collectively, they are referred to as a system. They are experienced by the patient as distinct and separate individuals, with their own way of perceiving the world and responding to it. Remember, they have been created in order to dilute the impact of the trauma on the abused child, and therefore will have different memories or perceptions of the abusive experience, or no memory of it at all. They have been created to perform different functions of life, thus the various genders, ages, ethnic backgrounds, names, and character traits, which are dependent upon their particular role within the system. Each personality may support its own style of dress, handwriting, speech pattern, mannerisms, walk, likes and dislikes, even eyeglass prescriptions, and responses to medications. One alter may even have a disease that the others do not, for example diabetes or asthma.

Often alters are created who express impulses perceived as forbidden by the child, such as anger, defiance, promiscuity, or violence.

The names of the alters often have a symbolic meaning. For example, Melody might be the name of a personality who expresses herself through music. Or the personality could be given the name of its function, such as "The Protector" or "The Perpetrator". The legal personality is the person with the legal name of the body, or the birth personality. This is also called the original personality and is the identity from which the first other personality split off. This may or may not be the same as the host personality. The host is the personality who has executive control of the body the greatest percentage of time. This host may have completely taken over the basic functions or daily life for a legal personality who is too overwhelmed to participate at all. Or the host might be the only one perceived by the system as being able to keep the system under control and intact.

The presenting personality is the one who presents for treatment. This may or may not be the host. This could be an alter whose immediate adult crisis, such as a relationship failure or problem at work, leads the body into therapy. Or it could be an alter suffering from the behavior of another, such as an unduly scrupulous alter suffering from the behavior of a promiscuous one, The most commonly found personality in the repertoire of the MPD is that of a child who is terrified and remembers the abuse. The next most common is the persecutor who is usually

modeled after the abuser., Because the individual feels incapable of integrating all the functions of life into one personality, alters are created to perform the various roles of maintaining a job, parenting, being sexually active, and any number of other functions. The individual is broken down into components that when put together can rise to the complex demands of life.

In referring to themselves, multiples often use the pronoun "we". In referring to the different personalities as a whole they may use such terms as the system, the family, the troups, my people, or the kids if there is a large number of child personalities.

The awareness of one personality to tell others is called "co-consciousness" and exists in varying degrees. Some may be totally unaware of the existence of the others. Some may be aware of the existence of others but not have any interaction with them. Only one personality interacts with the external environment at a given moment. A personality is referred to as being "out" when they have executive control of the body at a given moment. The others may or may not perceive or influence what is going on. This is an important phenomenon for healthcare personnel to grasp. Though one alter has met the assigned nursing staff, another may not have. Don't assume the patient knows your name, trusts you, or is familiar with a particular hospital routine. Introductions and explanations may need to be made to each alter as they appear. The personalities can become quite narcissistic, developing such an investment in their separateness that one or several alters ay try to kill others. Because they see themselves as separate and distinct entities, they fail to understand that they share the same body. Thus, they cannot grasp that killing one alter, kills the entire system. This is often when the patient presents to the psychiatric professional for the first time. Suicidal impulses and/or attempts, or self-mutilation will often bring the patient, who has been able to function fairly well in life, finally to the attention of those who can help.

An alter may exert its influence without ever seizing executive control. For example, if this alter is the persecutor, the patient may experience inward conflict without this alter ever presenting to the outside world. It makes itself known to the patient through threats and insults, which are heard as command hallucinations. Or the persecutor can take over the domain of motor control, perhaps telling the patient to drive off a cliff, but still has never presented to the onlooker. The personality in charge at the time will describe the experience as imposed rather than willed, which can be quite confusing and disconcerting, particularly to the individual who has no idea of his or her multiplicity.

Transition from one personality to another is referred to as "switching." This usually occurs within seconds to minutes, but can also be gradual, taking hours or days to complete. This is rarer. Switching is often prompted by stress in the individual's life, or by the person's own intrapsychic conflict, such as vague memories of abuse. Switching can also be brought on by alters who are in conflict with one another, which happens quite frequently. They will have different ideas about the way life should be lived, relationships conducted, how much to trust someone, or whether or not to take a medication.

Environmentally triggered cues, or "triggers", can also provoke switching. A musty smell may remind a patient of being locked in a dark, damp closet as a child. Or eating red mean

could trigger a response in the survivor of cult abuse who remembers rituals involving cannibalism. The individual might then switch ito the abused and helpless child alter, or the persecutor, or even a strong and aggressive alter who becomes violent and fights the abuser in a way the child never could.

During times of high stress or provocation of whatever sort, switching can be so rapid that the individual becomes depleted and confused. This is a time when nursing staff can take the patient aside to a quiet place to do a reality check and to help the patient feel safe and comforted.

In psychotherapy, switching is sometimes encouraged by the use of hypnosis, with or without the use of a sedative called amobarbital (amytal). This helps the therapist to access all alters, particularly those who are reluctant to come out, and thereby work with the system as a whole.

The individual with MPD may have cycles in his or her life where the actual overt behavior of multiplicity is not seen. These cycles of overt versus covert behaviors are quite typical. For example, a common motive or task may render alter activity covert temporarily, until the task is complete. Motherhood is an example. The alters may collaborate to raise the child, with no overt signs of MPS for several years,. However, when the child is grown and has left home, or become more independent, the alters once again diverge into their separate identities and purposes, and may suddenly appear in a more covert manner.

Some may be more overt in behavior due to secondary gain. If the behavior is reinforced and exploited by others, or if the behavior suddenly brings them the attention and nurturing they missed as a child, for example in hospitalization, they may be encouraged to be more overt. (Kluft, 1991a)

However, Kluft maintains that “dramatic external differences are not the core of MPD.” (Kluft, 1991a). If the alters influence each other by inner dialogue, there may never be overt signs of MPD. If this communication is in the form of inner threats, the presentation can appear psychotic. If in their influence they do so by seizing complete executive control, the classic overt signs or MPD may be this time be seen, with obvious switching and differences between alters.

The amnestic barrier is also a determinant of overt versus covert behavior. If the alters share the same contemporary memories, one can easily discount their overt differences because of the consistent descriptions of their lives. However, if they have their own separate versions of their contemporary lives, the observer will see the presence of dissociative phenomena. If alters are similar it will diminish the overt signs of MPD. The signs of MPD are not as obvious as one might think, and may only be apparent to those who know the patient very well. Though different personalities exist, the differences may be very subtle. Kluft has found from his experience that approximately 20% of MPD patients spend most of their adult lives in an overt MPD presentation.. Of these, approximately only 6% make an overt presentation on an ongoing basis and try to draw attention themselves. The remaining 14% are overtly MPD on an ongoing

basis, but do not call attention to themselves and try to keep their condition covert. Forty percent show signs that could alert a skilled clinician and the remaining 40% are highly disguised. (Kluft,1991a)

These statistics from Kluft help us to understand then, the difficulty in diagnosing a disorder that one might erroneously believe to be so dramatic that it would be obvious to anyone in the patient's presence. It is well to remember that this is a disorder of intense secrecy, and the alters may have a firm pact to remain hidden. The patient will often vehemently deny the suggestion of MPD if confronted.

COMMON ALTER PERSONALITIES

Child and adolescent alter personalities

These are the most common types of alter personalities and are often the first discovered during therapy. (Fike, 1990a) Child and adolescent alters emerged to endure the abuse that the original personality could not tolerate or to handle feelings that were unacceptable to the original personality. Child alters will often say that they do not know how to play, that they feel unloved and that they d not have any friends. In a sense, this is exactly their experience. Since their access to the body was usually during the abuse, this is the only experience they know. Even though the original child personality may have had friends and played as any child would, the child alter was created for the purpose of handling the abuse only. To the original personality, it is the child alter who is experiencing the abuse. The child thinks, "It is happening to her, not to me", so she can therefore be relieved of the pain and emotional anguish over her participation in the abusive experience. Art and play therapy are ways the child alters can be reached and encouraged to express themselves, just as one might work with a true child of stated age.

Protective or rescuer alter personalities

These alters were created to save the original or other personalities from intolerable conditions. They may have intervened by fighting or defending themselves through trickery, pretense, or running away. Protective alters can be of any age group and are generally much tougher and braver than the original personality. (Fike, 1990a) The other weaker personalities often feel a sense of shame in comparison to the Protective alter.. "He is so strong and I am so weak. I couldn't take care of myself." They may feel shame that the abuse happened to them, but that the personalities can be helpful during therapy, but can become resistant or hostile if they feel that their job of protecting is being threatened. (Fike, 1990a)

Persecutor alter personalities

These alters are modeled after the abuser. The perspective behavior can be demonstrated in different forms. Patients report taunting and negative messages that they hear inside their heads, blaming the patient for abuse, condemning, threatening to hurt the patient, and telling them they need to die, or to pay for succumbing to the abuser. Often the host will act on these messages and this is commonly when the patient becomes introduced to the mental health

system. They may cut or burn themselves in self-mutilation, or may actually make a serious suicide attempt. During therapy the patient may become terrified because the persecutor is threatening to kill the host for sharing information about the abuse or the personality system. The host and alters are sometimes very frightened by the feelings and/or ideas of another alter, in as much as they feel they have no control over, or protection from, the other's actions.

Though difficult to understand at times, self-injury does sin fact serve a certain purpose. Patients report a sense of relief after self-mutilation. They often feel they deserve to be punishment and will temporarily feel better because they have paid for being bad. Self-mutilation can also be seen as a protective mechanism; MPD patients believe they are avoiding more grotesque harm from the abuser, because they have instead hurt themselves. (Fike, 1990a)

It is important to see that these alters were originally created as a defense mechanism. Though this mechanism might have kept the child alive in the past, in adult life it only serves as a negative influence. Understanding the rationale for self-abuse is essential for cessation of the behavior. The persecutor personality must begin to understand that, though this behavior was important to survival in the past, it is no longer helpful.

Perpetrator alter personalities

Perpetrator alters, like persecutors, are modeled after the original abuser, and like persecutor personalities. Unlike persecutor alters however, perpetrator alters seldom direct their abusive behavior inward to injure other personalities shared by the body. Rather, perpetrators direct their behavior outward towards others. No matter how unacceptable their behavior may be, it is essential to remember that perpetrator alters were essential to the survival of the child who was abused.

There are two types of perpetrator alter personalities. The first is the personality created to handle the abhorrent behavior demanded by a cult. Upon paid of death or torture, cult members are expected to participate in hideous acts of cannibalism, group sex, and violence. For the children of members there is no escape but an inward one. To emotionally survive this type of experience an alter must be created who participates, otherwise the terrified child could not survive such an extraordinary experience. This first type of perpetrator alter is the one who was forced by the abuser to abuse others, but no longer participates in such abuse. In therapy it is important to help these alters to understand their earlier behavior as a survival mechanism and begin to develop a more positive self-image. (Fike, 1990a)

The second type of perpetrator personality is one who continues that earlier abusive behavior in adult life. These are the men whose violent crimes, such as rape or child molestation, eventually find them in the criminal justice system. Women who have an active perpetrator tend to abuse their children in ways that were similar to their own abuse. (Fisk, 1990a)

Avenger Alter Personalities

The avenger holds the rage from the childhood abuse and may attempt to avenge themselves or seek retribution from the abuser. They express the anger of the entire system and can be very hostile and negative. However, this is a personality that therapists often like to work with, because the avenger expresses the anger that the therapist also feels. A goal of therapy with the avenger is to find ways to express the anger I a satisfying and yet socially acceptable manner.

Self-destroyer Alter Personalities

"Self-destroyer alter personalities are considered special purpose fragments rather than full alter personalities and are generally found only in survivors of cult abuse." (Fike, 1990a) Although suicidal alters are certainly present in most patients with multiple personality disorder, the self-destroyer is different in that it was created by the cult for the sole purpose of destroying the body should the individual disclose secrets of the cult. This alter was created through the use of abuse or torture, and explains the extreme secrecy of these patients. The internal conflict for these patients in therapy is great, and it is very difficult for the therapist to obtain a true history of the abuse. It is only after a great trust has been established that the patient is able to disclose cult information in therapy, and then it is with great fear.

Often the self-destroyer does not become evident until a suicide attempt has been made and it can be related to recent disclosure of cult activities. It is then important to do whatever is necessary to protect the patient from further self-harm.

Internal Self-helpers

These alters can be extremely helpful in therapy, if they exist. Not every patient with MPD has an internal self-helper. Also referred to as observers, advisors, or organizers, they are the rational part of the system, with either controlled or non-existent emotions. This alter is able to watch all the other personalities, report what the others are doing and how they are reacting to certain situations. They are able to assist the therapist in providing the appropriate intervention to each alter.

Opposite Sex and Opposite Sexual Preference Personalities

It is common for individuals with MPD to have alters of a different sex or opposite sexual preference than the host personality. These personalities are often created to express feelings or behaviors that the host feels are unacceptable. For example, a female patient may create a strong aggressive male avenger personality because she doesn't feel capable of expressing those qualities herself, or she may feel those qualities are unacceptable to society as a whole.

These personalities can also be created to play a specific role demanded by the abuser during the abuse experience. If a boy were forced to dress and act as a little girl, he may create a female sister to play that role.

These alters can present difficulties as they relate to society in the body of the host. Opposite sex alters and alters that prefer a different sex than the host can present difficulties in relationships. These alters also create conflict when an opposite sex alter takes over in actions that would be socially incorrect for the sex of the host, For example, a little boy alter of a female host who wants to remove his shirt when he's hot or use a public restroom for men.

In therapy the opposite sex alters are brought to an agreement about socially acceptable behaviors for the host.

Alter Personalities of a Different Race/Ethnicity

Different race alters are generally created for the stereotypic or imagined qualities of that race, as experienced or perceived b the host personality. Fike gives the example of a Caucasian patient with a Native American alter personality who represented spirituality and other-worldliness. Another example is that of a Caucasian woman with a black male child protective alter. As a child she had a Black classmate who she described as "the toughest kid on the block." (Fike, 1990a)

These alters can even speak a different language than the host. For example, a Spanish speaking female self-helper was created by a Caucasian female, because the only love or nurturing she received as a child was from the Spanish-speaking housekeeper. The host personality may not know a single word of Spanish.

Older Alter Personalities

Often this type of alter is created to serve a nurturing or parenting role, thus serving as a protector. However, sometimes the age is related to taking on the identification of the abuser, and can therefore take on any of the other more hostile roles.

Nonhuman Alter Personalities

Though these alters can seem unbelievable, they are actually quite common among patients with MPD. The two types of nonhuman alters most commonly seen are animal alters and demonic/mythological alters. An example of an animal alter is a young woman who would bark like a dog whenever she felt threatened and did not want to answer questions. Since a dog cannot make itself understood in human terms, by sending this alter out there was certainly no way a therapist could pry for information. Once again we see a very fine tuned defense system.

It is important to remember than when an animal alter is out, to the host body this is actually and in reality, a dog. With this in mind anyone working with the patient should be careful about touching the patient when an animal alter is out, in the event this is an unfriendly animal, or perhaps one who functions as a protector.

In some cases, what presents as an animal is really a child alter acting as an animal. This is found in cases where the abused child was forced to act as an animal, usually a dog, and may

have included sexual acts with dogs. These alters will speak as a human and will demonstrate confusion over whether they are an animal or a child. In these cases the therapist reinforces the humanity of the alter and will address the alter as a child, rather than as an animal. To treat this alter as an animal would be to reinforce the abuse and identify with the abuser. (Fike, 1990a) Demonic alter personalities are found in victims or satanic cults, while mythological god alter personalities are common in patients with fanatic religious backgrounds. These alters are described by patients as all-powerful and all-knowing, and may have either good or evil qualities. The role of these alters is to protect the body. Though the therapist must acknowledge the existence of these demonic or mythological alters, they should not reinforce the patient's belief in the power of these alters. The therapist might say something like, "I know you believe you control all things, but I do not believe I am controlled by anyone. I believe I can make my own choices. (Fike, 1990a)

All of the above alter personalities can present in a variety of combinations together. For example, the patient is a middle-aged Caucasian female. She may have a black male child alter, a lesbian protector, an older male perpetrator, an older female goddess-like rescuer, and a wise Chinese female self-helper, to name only a few of the many personalities that may emerge.

Though the manifestation of these alter personalities can seem fantastic and unbelievable, it is important to remember that the patient sincerely believes each one to be a separate and real entity, with its own experiences, thoughts and ways of interacting with the world. Each personality must be recognized and respected for who they are in order to treat the whole patient.

MAKING THE DIAGNOSIS

Studies have shown MPD patients to be polysymptomatic with a combination of dissociative, affective, posttraumatic, and somatic symptoms. This polysymptomatic presentation, along with cetain core characteristics of MPD makes it an extremely difficult disorder to diagnose. The average MPD patient receives three erroneous diagnoses, spends approximately seven years in therapy and has three of more hospitalizations before receiving an accurate diagnosis and appropriate treatment.

Kluft (1991a) has gathered data from studies by several clinicians to demonstrate the polysymptomatic presentation of MPD patients. The data depicts the percentage of MPD patients who experienced the following concomitant psychiatric or medical disorders:

Anxiety – psychopbysiological = 100%
Phobic = 60%
Panic attacks = 55%
Obsessive-compulsive = 35%
Affective symptoms – depressive = 90%
High = range 15 – 73%
Allied dissociative symptoms – Amnesias = range 57 – 100%
Fugues = range 48 – 60%

Depersonalization = 38%
Somatoform symptoms – All = 90%
Conversion = 60%
Sexual dysfunctions = range 60 – 84%
Suicide attempts = range 60 – 68%
Self-mutilation = 34%
Psychoactive substance abuse = 40 – 45%
Eating disorders = range 16 – 40%
Sleep disturbance = 65%
Symptoms suggestive of schizophrenia – depending on symptoms = 35 – 73%
Symptoms of posttraumatic stress disorder (PTSD) = 70 – 85%
Stigmata of borderline personality disorder = 70%

Overview of Characteristics

The secrecy, denial and suppression so characteristic of the MPD patient make it extremely difficult to obtain an accurate history. In most cases the individual, along with the alter personalities, are very committed to keeping the disorder hidden. The secrecy can be attributed to shame around the abusive events, embarrassment about the dysfunctional behavior, or may parallel the secrecy enforced in the abusive dysfunctional family. This is particularly rue of survivors of cult abuse, where the child was repeatedly programmed with threats not to divulge cult information or experience.

The evasiveness of these individuals can also largely be due to the reluctance of uncovering painful memories of abuse, reliving them as they share them in therapy.

Embarrassment over lost periods of time may lead the MPD patient to confabulate a history in order not to appear crazy. They may even access the memories of a particular alter or several alters, without realizing they have done this.

Concomitant Axis I and II diagnoses will further complicate the picture. MPD patients present with such a varied cluster of behaviors and disorders that a clear diagnosis of MPD becomes difficult. This accounts for the many years the typical MPD patient spends in the mental health system before receiving the correct diagnosis.

Kluft also maintains that, given the cycles of covert versus overt behavior, there are windows of diagnosability when diagnosis can easily be made, otherwise it can be completely missed. (Kluft, d) These "windows" are periods of high stress which would provoke increased alter activity or conflict.

Another contributing factor to the misdiagnosing of MPD is that different alters may present at different times to different therapists and each be given a different diagnosis.

Individuals experiencing any level of dissociative disorder do not necessarily seek therapy because they are aware of the dissociative behavior. In fact, they are often not aware of it at all. It has been found that only five percent of MPD patients enter therapy self-diagnosed. (Steele, 1989) What they are aware of is simply not feeling right, or of feeling absolutely crazy without knowing why. They may seek therapy because someone brings their bizarre behavior to their attention, or because other things in their lives are not going well. Relationship or job conflicts, family issues, generalized stress or depression, or suicidal impulses may all lead MPD patients to seek professional help.

Drug and alcohol abuse, as well as eating disorders, are often seen in individuals with MPD. In fact, it is often after the addiction has been dealt with and the patient abstains from the addictive behavior that the multiplicity is seen for the first time. Chemical addictions numb the psychic pain from the trauma and the internal conflicts of the personalities. Once the patient is clean and sober the pain is acutely felt and the activities of the alters become more clear. Individuals with MPD who are in recovery for substance abuse need an extreme amount of support and professional help to continue working through the trauma instead of resorting to the old defense mechanism of numbing through chemicals.

Eating disorders, as well, can be seen as a defense mechanism against the chaos of the internal system. The core component of an eating disorder is the issue of control. The individual can control this one aspect of his or her life in a world that feels totally out of control. Eating disorders can also be experienced as punitive, denying or punishing the shameful child who participated in the abuse and who now lives a secret life. A study by Demitrack et al found that the self-destructive and suicidal behavior in eating disorder patients could be linked to dissociation rather than to impulsivity or depression. (Kluft, 1991b)

The MPD patient is often in an abusive relationship. This keeps the individual reliving the abusive past which he or she has not yet come to terms with.

The amnesia and loss of periods of time can be explained by the alter activity. If there is no-co-consciousness the host personality has no idea when other alters are out. When the host returns, the patient will experience a gap of time which can't be explained. This causes confusion and disorientation.

A fairly classic presentation of an MPD patient is the depressed and depleted female between the

ages of 20 to 50, who is often intelligent and accomplished, with persistent somatic complaints that are unresponsive to usual treatment modalities, and who has been exposed to psychiatric treatment without success.

Signs and Symptoms of MPD

The behaviors, complaints and histories of the MPD patient will provide much information that could lead a clinician to suspect MPD. A careful history taking and observation of the MPD patient will yield many of the following signs and symptoms (Kluft, 1989a; Braun, 1990):

- Prior treatment failure
- Three or more prior psychiatric or medical diagnoses
- Concurrent psychiatric and somatic symptoms – severe headaches, anxiety, chest pain/palpitations, fluctuations in pain threshold, dizziness, nausea without pregnancy, gastrointestinal problems, menstrual and gynecological irregularities, fear of dying depression, mood swings, phobias, unpredictable responses to medication (e.g., sudden alterations in insulin requirement)
- Body memories – unexplained somatic complaints which is the body relieving physical pain from an abusive experience (e.g., numbing of the hands from a patient whose wrists were tied up during the childhood abuse episodes; choking sensation with a patient who was forced into oral sex as a child)
- Fluctuating symptoms and level of function
- Time distortion or time lapses
- Amnesia – particularly in large gaps of childhood
- Being informed of behaviors the patient does not remember
- Inconsistencies in physical behavior – voice changes, changes in facial expression, switching in right or left handedness, substantial differences in clothing worn on the first and subsequent visits, differences in hair style and facial makeup on different visits
- Discovery of productions, objects, or handwriting in one's possession that one cannot account for or recognize
- The hearing of voices (> 80% experienced as within the head), experienced as separate urging toward some good or bad activity.

- The use of "we" in a collective sense
- The elicit ability of other alters through hypnosis and/or amytal
- A history of child abuse, or of a family history of dissociative disorders (there is evidence that MPD is transgenerational)
- The sense that one's mind and/or body are being influenced or changed – feeling in a daze, confused, going into a trance, thoughts out of control, disoriented, vocalizing words one did not think to speak, difficulty understanding others

Differential Diagnosis

The most common differential diagnoses are schizophrenia and borderline personality disorder. Because the MPD patient hears voices, he or she may appear to have the auditory hallucinations of psychosis. However, the schizophrenic patient will experiences vices heard outside the head most of the time, whereas the MPD patient usually hears them inside the head. MPD's are oriented to reality and their perceptions of the world are logical and intact.

Schizophrenics, on the other hand, have a skewed sense of reality where there are no clear boundaries or delineations between the various elements of their world. Because MPD patients sometimes feel they are possessed or controlled by another being, this can appear to be delusional material of a psychotic disorder.

The switching of personalities can be mistaken for the instability of mod, self-image, and interpersonal behavior that characterizes borderline personality disorder. This disorder can, however co-exist with MPD.

An MPD patient can be misdiagnosed with psychogenic fugue or psychogenic amnesia. Though these are often features of MPD, these disorders in and of themselves are usually limited to a single brief episode and do not demonstrate the repeated identity changes characteristic of MPD.

Not only is the diagnosis difficult based on how the patient presents, but critics in the mental health community have made the validity of the disorder an issue. Because of the increase in reported cases in the past decade, clinicians have been accused of overzealousness in making the diagnosis, or of iatrogenesis. It is suggested that clinicians respond with curiosity and interest when patients reveal potentially dissociative qualities, thus the patient is encouraged to continue and expound on dissociative behavior when,, in fact, it may not exist. There is also concern that malingering may be encouraged because the patient receives so much secondary gain free sharing traumatic childhood material.

Concomitant Axis I and Axis II Diagnoses

It is common for the MPD patient to have other co-existing psychiatric pathology. Some of the most common of these are borderline personality disorder and affective disorders. A study by Horevitz and Braun found that 70% of MPD patients also fit the DSM-III-R criteria for borderline personality disorder. (Kluft, d) Depression is the most common chief complaint among MPD patients, documented in over 90% of cases. Many MPD patients are thought to be bipolar, due to the rapid cycling seen during periods of high stress and/or extreme conflict between alters.

Diagnostic Tools

Direct questioning about traumatic events or amnesia can be very threatening, or may not even be known by the presenting personality. Also, when asked about amnesia or time losses, the patient is embarrassed or fearful of being labeled crazy.

Indirect questioning is more appropriate and productive. Questions about unexplained objects in one's possession, relationships, presence of skills or writing tht is ot familiar will often yield helpful information. In history, taking, sudden and inexplicable changes in behavior or performance can be quite telling. For example, an honor student who suddenly fails a test, or the secretary who is always conscientious but has turned slovenly and disinterested might suggest alternate personality activity.

Suggesting the MPD patient write in a diary for thirty minutes per day can provide considerable information. Different personalities will interrupt and different writing styles and content will be noted.

Hypnosis can be very helpful in making the diagnosis. Dissociative patients are extremely susceptible to undergoing hypnosis. In this state alter personalities can easily be drawn. If the patient does not have MPD there will be no forthcoming alters.

Amytal is a sedative hypnotic drug which is often used during hypnosis to help the patient relax enough to undergo this type of interview process.

In the past few years specific diagnostic tests have been developed to aid in the diagnosis of MPD. They should be used as an adjunct to the taking of a careful and in depth history, and to the observations the clinician makes of repeated visits. These diagnostic tests are ot definitive for MPD by themselves. The diagnostic tests include:

- The Dissociative Experiences Scale (DES)
- The Dissociative Disorders Interview Schedule (DDIS)
- The Hypnotic Induction Profile (HIP)
- The Structured Clinical Interview for DSM-III-R
  Dissociative Disorders (SCID-D) (the author of this test, Marlene Steinberg, M.D. describes it as "more than 90% sensitive for true known MPD." (Kluft, 1991a)

Malingering

Due to the secondary gain a non-MPD patient might gain from the diagnosis of MPD, malingering becomes quite problematic. A diagnostic tool in this instance would be to remember the innate secrecy and embarrassment of a true MPD patient. A patient too eager to share traumatic childhood material should raise a margin of suspicion in the clinician.

Malingerers will generally follow a pathological course they have learned from lay sources, overstate their case in an attempt to convince the therapist they have MPD, and demonstrate inconsistencies in the presentation of alters.

If malingering is suspected hypnosis can be very helpful. As stated above, these individuals will be inconsistent in the presentations of alters, and often overly dramatic based on how they believe such a patient would behave. A true MPD patient under hypnosis will demonstrate alters whose behavior is consistent with repeated hypnotic sessions.

A diagnosis of malingering can also be substantiated by checking past hospital and police records.

COMMON PRESENTATIONS OF MPD

Kluft seeks to discourage stereotypic thinking about the presentation of MPD, because very few patients spend much of their lives in a classic presentation. He describes the following as common presentations of MPD: (Kluft, 1991a)

Classic MPD

Overt behavior that fits the diagnostic criteria for MPD on an ongoing basis for periods of months, years, or even a lifetime.

Variant Forms

Patients with the classic phenomena of MPD, but their manifestations are intermittent or have unique features which makes diagnosis difficult.

Latent MPD – The alters are generally inactive but may be triggered by stressors which are somehow symbolic of the traumatic event. Examples of this are when the patient's children reach the age of the patient during the trauma, or the perpetrator becomes ill or dies. During such time the alters may emerge for the first time publically, which provides a window of diagnosability.

Posttraumatic MPD – Symptoms are not present until the patient experiences an overwhelming contemporary event such as a great loss, rape, combat, or a head trauma sufficient to cause organic amnesia.

Extremely Complex or Polyfragmented MPD – Presence of such a wide variety of alter personalities with such frequent switching between alters that it is difficult to discern the outline of MPD and the multiplicity actually disguises itself.

Epochal or Sequential MPD – When an alter emerges it takes over for a long period of time before the next alter takes over for another long period of time. While one alter is out, the others go dormant.

Isomorphic MPD – Several very similar alters take control as a group and try to pass as one. The only overt signs may be a fluctuating level of function, unevenness of memory, or inconsistencies in the patient's personality. Kluft's example is "she's quite bright, but what an airhead!"

Co-conscious MPD – The alters know about one another so there is no demonstrated time loss or memory gaps.

Possession Form MPD – The most evident alter presents as a demon or devil. This can be seen more commonly in cultures where religion or rituals have to do with demons and can easily be mistaken for psychotic conditions.

Reincarnation/Mediumistic MPD – Alters who are experienced by the patient as having a supernatural quality and communicate with the patient in such a manner.

ATYPICAL MPD A group of patients that is rarely diagnosed.

Private MPD – Alters are aware of one another and have consciously adapted to pass as one.

SECRET MPT Closely related to Atypical MPD. The host is unaware of the alters, who only emerge when the host is alone. One might suspect this in a patient who cannot account for his or her private time.

Ostensible Imaginary Companionship MPD – The patient has an adult version of the imaginary companion who is friendly and supportive with the other socially constricted host. What the patient is not aware of is that this entity does assume executive control and that there are other alters present as well.

COVERT MPD **T**his is the form most characteristic of patients with MPD. Alters contend for control and influence without assuming full executive control. To patients is feels as though their lives are out of control and that their actions are imposed upon them by a power unseen rather than selected by them.

Puppeteering or Passive-Influence Dominated MPD – The host is dominated by alters that rarely emerge. If the host is unaware of these alters he/she feels like the victim of influences that force behavior in a direction not chosen.

Phenocopy MPD – The most important of the covert forms. Occurs when the alter's interactions with, and influences on the host and each other, create phenomena that are similar in appearance to the manifestations of other mental disorders. For example, alters who are in conflict and are insistent on their thoughts while cancelling out one another's actions can imitate obsessive compulsive disorder. When a patient has alters who harass one another, it appears to the onlooker as though the patient is hallucinating, which would resemble an acute schizophrenic episode. Alters with different moods can have the appearance of an affective disorder. Alters in contention may create the chaotic appearance of borderline personality disorder.

Somatoform MPD – Very common. The pain or discomfort of a traumatic event which was experienced by an alter, is felt physically by the host, who has no memory of the trauma. Examples are pain in the rectum or vaginal area, numbness or tingling in the extremities from being tied up during abuse, a sense of choking or nausea associated with forced oral sex. This should be suspected when there is no apparent physiological explanation for the pain.

Orphan Symptom MPD – Closely related to all of the covert categories. This is the phenomenon of unexplained and spontaneous feelings, sensations, actions, or intrusive traumatic imagery which manifests in the host, is not understood by the host, and which has been triggered by a contemporary stimulus that relates to the childhood trauma.

MISCELLANEOUS PRESENTATIONS OF MPT

Switch-Dominated MPD – Most commonly seen in the patient with a large number of alters. The switching process is so rapid and frequent that the patient appears bewildered and forgetful. Patients are often misdiagnosed with an affective disorder, psychosis, and organic mental syndrome, or seizure disorder.

Ad Hoc MPD – Very rare. A helper alter creates a series of alters that function briefly and then cease to exist. This can be suspected when the patient's history may suggest MPD or recurrent fugues, but no alter can be found to explain the missing time.

Modular MPD – Very uncommon. This occurs when usually autonomous ego functions split and different personalities are reconfigured from their elements. When an alter is encountered it may have a vague feeling to it, and may never be seen in exactly the same way again. These patients have been seriously abused, and are brilliant and quite creative. Kluft has also found an unusual computer literacy since childhood among these patients.

Quasi-Role-Playing MPD – In this case the patient is attempting to disavow the diagnosis of MPD. One alter acts out when it knows of the other alters, and then informs the clinician that he/she has been feigning MPD. The patient states they have willfully generated this behavior. In the 11970's and 1980's this was seen exclusively in mental health professionals. Now it is also found in sophisticated lay persons.

Pseudo False Positive MPD – This presentation was common in the 1970's and 1980's and is now uncommon. In this case a patient would adopt the behavior of a widely publicized or

Hollywood movie type of case, one that is very flamboyant in appearance. The purpose of this was a desperate attempt to convince the clinician of the presence of MPD, while the patient anticipated incredulity on the part of the clinician. Now that MPD is accepted as a valid diagnosis, this presentation is rarely seen.

TREATMENT

Treatment of MPD is difficult due to the various core characteristics of the disorder. Breaking through the intense secrecy to access the personalities and the traumatic memories is a first step. Then treatment is continually compromised by dissociation, the impaired continuous memory, and switching in response to stress. The individual lacks a stable observing ego, which affects the patient's ability to report history, to learn from experience, or to have insight.

Because the various alters may have different issues, different feelings, and a different sense of commitment to therapy, it is important to get the system to agree to work toward common goals. (Kluft, 1989b) The internal conflicts among alters, the power struggles and the switching will create endless crises. One alter may harm another for sharing information, or another may completely withdraw the patient from therapy.

The alters must be worked with to put their narcissistic investments aside, and must begin to empathize, to identify themselves as a whole, and to compromise in order to eventually work cooperatively as one.

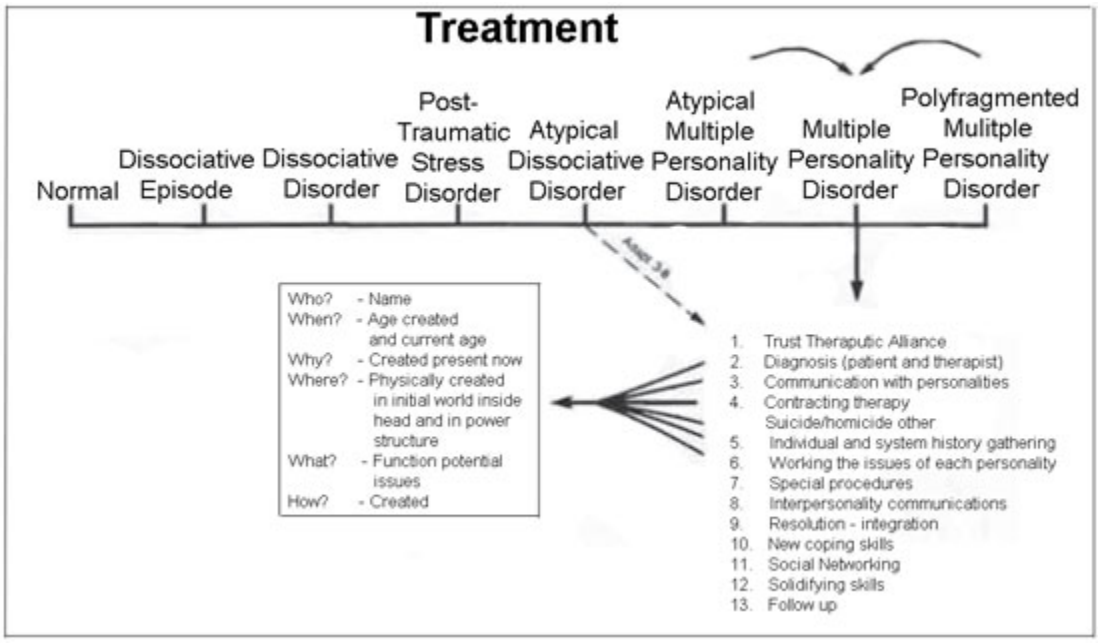
Braun suggests the therapist must be aware of and address four specific issues: (Braun, 1990)

1. Consistency – The therapist must be consistent and at the same time flexible. It is important to remember that the patient has been conditioned by authority figures whose rigid yet unpredictable behavior has led to a general distrust of others. The patient will test the therapist into actions that will prove he or she is as unreliable and inconsistent as the adults who shaped the impressions of the abused child.

2. Counter transference – The patient will likely have transference issues with the therapist during the course of therapy. Likewise, the therapist can easily develop counter transference with the patient. In an effort to maintain a status quo of abusive and unhealthy relationships, he patient may be accusatory with the therapist and the therapist must be careful not to personalize any of this behavior. It is important to see it for what it is – the desperate attempt of a very sick person to fit every experience into the framework they came to know as a child.

3. Double-bind set-ups – For the same reasons as mentioned in #2, the patient may set up double-bind situations where the therapist will be shown an uncaring or abusive, For example, a therapist checking up on a missed appointment may be accused of being too authoritarian. However, if the therapist did not follow-up, the patient might complain he or she is uncaring, The patient sets up a no win situation to once again fit this new experience into the pattern of old ones.

4. Trustworthiness – the MPD patient will constantly test the therapist's trustworthiness. In this testing they may try to make deals such as, "I'll share information with you if you'll keep it a secret." It is important to the therapeutic relationship for the therapist to be up front and completely honest about the obligation to share pertinent information with the therapeutic team for the purpose of helping the patient achieve treatment goals. It is also important to share information with the patient regarding diagnosis, medical issues and treatment plans. Be very careful not to hedge issues or behave in any way that could be perceived by the patient as a covert plot to do him or her harm. The patient must be able to trust that, inasmuch as he/she is honest about history, memories and experiences, the therapist is honest about any treatment issues.



APPROACH TO TREATMENT

Referring to figure 3 (Braun, 1990). Braun discusses a 13-Point approach to treatment of MPD. Although the therapeutic issues are shown in a particular order, in therapy they can be worked on back and forth to capitalize on whatever treatment issues is at hand, and to go with the general flow of therapy. Summarized below:

TRUST – Enough trust to continue the work of a difficult therapy. Must be reinforced and reestablished throughout the therapeutic process. Must be established with each personality. Rarely complete until the end of therapy.

DIAGNOSIS – The diagnosis is difficult to make and difficult to share, It is done in a gentle manner when the patient is comfortable in therapy and the therapist has sufficient data and observations to present in a matter-of-fact way, Reactions of the patient can include relief, recognition, fear, and disbelief. (Steele, 1989) It can feel very frightening to a patient not only

because the disorder carries with it certain preconceived notions, but because he secret of childhood abuse, which the whole system has worked so hard to conceal, has finally been exposed. The abused child is terrified of exposure and the alters who have been created to handle that abused child's life may now act out in any number of ways. The therapeutic team must be aware of this and deal with the behaviors of the various alters as necessary, It is important at this juncture to help the patient feel safe, now that the dreaded secret is out.

COMMUNICATION WITH PERSOSNALITIES – Now that the initial trust has been established and the diagnosis shared the therapist will seek to communicate with each personality. The patient may be more comfortable communicating in a less direct way than traditional psychotherapy. Adjuncts such as art therapy or play therapy can be very useful. Hypnosis to draw out reluctant alters is also helpful.

CONTRACTING – Contract with the alters to attend treatment and to agree to not harm themselves, other alters, or the body they share. The patient must constantly be evaluated for self-destructive behavior, particularly after a therapy session where a disturbing memory may have been accessed. Contracting, whether verbal or written, should be done as often as needed. This could be anywhere from once a day to every hour. Engage the patient's cooperation in gauging these feelings. Encourage them to let staff know when they have strong self-harm impulses, and also encourage them to participate in the suicidal precautions by having them report to the nurse at the appropriate time for check-in, rather than the nurse necessarily having to seek them out. This helps the patient to develop a new coping mechanism; recognizing a feeling and, rather than internalizing it, going outside themselves to seek help.

INDIVIDUAL AND SYSTEM HISTORY GATHERING – Much of the patient's history will be gathered indirectly at first. The therapist will gain certain information during a session; however other information will leak out gradually during the course of a day, in occupational therapy, in a group session, over dinner, in interactions with various staff members. It is important to be aware of and document all pertinent information as it is disclosed. Note, in particular, information about the alters, e.g. origin, function, problems, relation to the other alters.

WORKING THE ISSUES OF EACH PERSONALITY – Accessing the who, when, why, where, what, and how for each personality. Recognizing each personality as a distinct and separate entity, with its own issues and experiences. Issues worked out with one alter are generally not worked out with the others, in fact, they may not even be aware of what is happening with the others. This process involves helping alters focus on painful issues and setting limits on behavior.

SPECIAL PROCEDURES – Can be used as an adjunct to psychotherapy.

1) Mapping the system of personalities – identifying the personalities and organizing the system on paper.
2) Using a sand tray as a medium to express feelings or expose a secret they are unable to verbalize.

3) Occupational therapy – art, music, and movement therapies all help the patient express nonverbally what is difficult and painful to express in words.
4) Play therapy when working with child alters, just as one might do with an actual child patient.

INTERPERSONALITY COMMUNICATION – This is a step toward co-consciousness and integration. During the therapeutic activities mentioned above the presenting personality can be encouraged to share information with the others. Hypnosis is helpful with the step.

RESOLUTION AND INTEGRATION – Personalities blend rather than continue power struggles. Integration is generally followed by a period of physiologic adjustment that can last days Staff should be aware of the patient's heightened sensitivity to stimuli, such as light and sound, and uncoordinated body movements. Attention should be given at this time to the types of physical activities the patient participates in, as well as sleep or eating disturbances.

NEW COPING SKILLS – Patients learn and develop new intrapsychic defenses and coping mechanisms. Nursing staff can help patients to practice and solidify new skills, particularly as issues arise within the milieu of the hospital. Staff can validate the patient's feelings or responses to a situation and point out gains the patient demonstrates in ability to deal with a situation in a healthy adult manner.

SPECIAL NETWORKING – Find, support/after care groups within the community.

SOLIDIFYING SKILLS – As treatment progresses, reinforce positive gains and development of non-dissociative coping strategies.

FOLLOW-UP – It is important for the patient to continue therapy even after integration has been achieved to prevent relapse. Patients who abandon therapy after integration generally relapse within two to twenty-four months.

This goal of treatment is integration of the different personalities into a unified whole. However, sometimes all that can be achieved is to eliminate the conflict between personalities so that they can work collaboratively, rather than independently or antagonistically.

This is a frightening process for an MPD patient. The different personalities have protected the individual from uncovering the painful memories. Giving them up means having to face the hideous trauma alone. Since these personalities have actually kept the person alive, losing them can make the individual feel quite vulnerable. Also, integration may feel like homicide to the personalities, who each consider themselves separate and vital beings. They will resist treatment vehemently.

A therapist can reassure the patient that the intention is not to kill off the personalities. The emphasis is that each of the personalities is important and all ideas will be incorporated and addressed. The therapist will teach them how to be angry and how to have power in an appropriate manner so that the individual need not feel victimized again. The personalities are

encouraged to develop compassion for one another, rather than antagonism. The objective of treatment is to increase the individual's ability to function in the world and it can be done with the cooperation and commitment of all the personalities.

Integration refers to the mutual acceptance, empathy, and identification of all the different personalities. It is a process rather than a specific event. (Steele, 1989) Barriers are broken down and the personalities are able to come together. This does not mean that one alter becomes dominant or that a new healthy alter is created, or that suppression of alters occurs, giving the appearance of resolution. (Kluft, e)

Integration is described as three stable months of:

1) Continuity of contemporary memory,
2) Absence of overt behavioral signs of multiplicity,
3) Subjective sense of unity,
4) Absence of alter personalities on hypnotic re-exploration,
5) Modification of transference phenomena consistent with the bringing together of personalities, and
6) Clinical evidence that the unified patient's self-representation includes acknowledgement of attitudes and awareness which were previously segregated in separate personalities.

The recommended treatment of choice is psychoanalytic psychotherapy. Treatment modalities which are not seen as effective are analysis, behavioral approaches, or purely interpretive psychoanalytic therapy. (Kluft, e)

Two sessions per week at a pace that allows the patient respite from continuous exposure to the traumatic material is suggested. Because the emotional needs of the MPD patient can be endless and exhausting, the therapist must set firm, but non-punitive and non-rejecting limits. Once the amnesia is broken through, the patient will be in a state of chronic crisis for a long time. (Kluft, e)

Every personality of the state must be treated with a professional, yet gentle respectfulness. It must always be remembered that bringing up the memories is a very painful and frightening process. The clinical team must respect the patient's anxiety over dealing with the traumatic material from the past, and must remember that integration is the priority, rather than simply exploring interesting phenomena.

Though the feelings and functions of each personality are respected, this does not mean the professional condones irresponsible or socially inappropriate behavior. It is always important to protect the patient from dangerous behavior. An important part of therapy is for the patient to learn how to live and function in society.

The patient often mistrusts the therapist's motives in therapy. Trust is important in any therapeutic alliance and even more so with the MPD patient who learns to distrust at an early age. The patient will constantly test the clinical team's commitment and integrity, and the team

must make all attempts to respond with consistency and professionalism.

Family therapy with the patient's family of origin is generally not recommended in an adult MPD patient. The trauma usually comes from this family, and encountering them in therapy causes retraumatization of the patient. However, if the patient is a child, family intervention would be advisable. Therapy involving the patient's spouse and children is important in helping these significant others deal with the patient's unusual behavior, to help them gain an understanding of the disorder, and to offer them support.

HOSPITALIZATION

Patients with MPD should be treated on an outpatient basis as much as possible. (Kluft, 1991b) There is concern that hospital settings cause the patient to regress, as well as disrupting the continuity of ongoing therapy with the outpatient therapist.

An important aspect of outpatient therapy is to pace the treatment in such a way as to minimize the risk of the patient becoming overwhelmed, thus requiring hospitalization due to acts of self-harm.

However, despite the most careful outpatient treatment, MPD patients do often require hospitalization. They are prone to self-destructive impulses, thus hospitalization of the MPD patient is generally of a protective nature. Often it is helpful to hospitalize the patient in order to better access traumatic memories or to call forth reluctant alters. Because these patients may fear a loss of control if they were to delve too deeply into childhood memories, the hospital can provide a sense of safety and support in order to more freely let down defenses.

Length of hospital stay varies with the circumstances of the patient. It could be a few days to weeks for the patient in immediate crisis or an abrupt dysfunctional episode. This often happens after obtaining a difficult memory or a stressful contemporary event, particularly one involving a perceived rejection. Hospitalization might also be for several months for a patient

Whose alters are in chronic conflict, are continually sending threatening messages to the system with every therapeutic step, or who are so unstable and unpredictable in behavior that in order to progress forward in therapy they require the protective and supportive confines of the hospital.

Group therapy, particularly a heterogeneous group, for the unintegrated MPD patient is generally contraindicated. Because of their high level of suggestibility, MPD patients are very sensitive to the issues of others. They can become quite overwhelmed, producing anxiety and switching which is disruptive to the group process. The group leader must then divert attention from the group to deal with the dissociative behavior, thus causing the other patients to feel the MPD patient monopolizes staff time and receives special attention. The other members of the group can be left with guilt feelings of having caused the crisis in the PD patient.

Also, in a heterogeneous group setting, the MPD patient's material can sound so fantastic that it is disbelieved and the patient is accused of lying or attention seeking. This will make the MPD patient feel unsafe and abused, thus perpetuating the abusive history.

Even in a group entirely composed of MPD patients, if allowed to spontaneously share traumatic childhood material, patients will accomplish little more than re-traumatize themselves through the hearing of others' material.

Because MMPD patients in the initial phase of treatment are too disorganized and fragile to participate in interactive group therapy, task-oriented groups are a better option. These include such groups as occupational therapy, music therapy, movement therapy and art therapy. A specific non-emotional activity, such as drawing a tree or making a coffee mug csn help the patient to focus and get relief from the constant emotional charge and switching of personalities. Also, the projects created by alters can be used in psychotherapy as a means of helping the host to acknowledge the existence of alter personalities and the experiences that created them.

The treatment of MPD may seem somewhat paradoxical. In achieving integration the individual must first separate out all the alters to be dealt with individually in therapy,. The therapist must respect each alter's individuality and uniqueness, and deal with the memories and issues of each alter before they can be encouraged to cooperate towards the treatment goal of integration. In order to achieve integration the alters must recognize each other, become mutually sympathetic and then empathic, and finally to work together and merge, thus giving up their narcissistic commitment to individual identities. (Dawson, 1990)

Hypnotherapy can be a useful adjunct to psychotherapy. MPD can be seen as a chronic misuse of autohypnosis, wherein altered states of consciousness are created to encode different material. Thus, through hypnosis the therapist can better access alters, particularly those who are reluctant to present themselves in therapy. Work done with one alter does not necessarily impact others, so each alter must be drawn out and worked with separately. It is also a good method for working through the amnestic barrier that prevents the host or presenting personality from obtaining childhood memories of the abuse.

A specific technique known as abreactive therapy employs hypnosis to help dissociative patients remember the trauma. While in a hypnotic trance patients are guided back through the memory. All sense of time and space are lost and subjects will actually believe that they have gone back into the abusive experience. They will take on the voice, facial expressions and mannerisms of that age. The body will actually remember how it felt and will react as if the abuse is actually occurring. The patient will feel the intense emotions surrounding the trauma rather than dissociating from the feelings. It is the therapist's responsibility to help the patient feel safe and reassured that further harm cannot occur; that the experience happened in the past and is not happening now. The therapist acknowledges to the patient that the trauma was survived by the child and that the memory can now be survived by the adult. The patient receives validation and acceptance of the experience and the feelings surrounding it, rather than being punished for them as during the original abuse. The patient then processes the experience and feelings differently than when it originally occurred. This work is then communicated to other alters.

The treatment team can then help the patient to develop a new blame-free perspective of his or her part in the childhood abuse experience. By working though the traumatic events in a new adult way, rather than the abused child's fragmented way, the patient makes steps toward integration.

Amobarbital (amytal) interviews, sometimes in conjunction with videotaping and playing back to the patient, can be helpful in treatment. Amytal is a sedative hypnotic which helps the patient to relax and better access memories and/or alter personalities. The therapist must be judicious in this type of treatment, however. Although helpful to some patients, it is shocking and overwhelming to others. Patients are able to see for themselves the presentation of various alters. Timing is essential. The clinician must know when the patient is ready for this kind of aggressive treatment.

Mapping is another tool used in therapy that helps both the patient and therapist gain clarity about the personality system. It is a diagram that the patient makes of the system by using lines, circles, boxes or any other method of explaining who the different alters are, how and when they came into existence, and what their purpose is. This helps the therapist to understand how the alters interact with each other, and to anticipate potential conflicts during therapy.

DISCHARGE CRITERIA

In order to be discharged the goals of admission should have been achieved. This generally means the patient has regained control over behaviors, feelings, and impulses or that uncooperative alters have come to an agreement about the therapeutic process. The patient must be able to contract for safety, and demonstrate a sufficient support system for after-care. Continued outpatient work with a therapist is imperative to prevent relapse, and to continue the gains established in the hospital.

MEDICATION

Though there is no medication which treats the core psychopathology of MPD (e.g. those symptoms having to do with the actions and interactions of alter personalities), most patients have various other co-existing symptoms and conditions which must be addressed f treatment is to be successful. The manifestations of depression, anxiety, panic attacks, phobias, and transient psychoses can interfere with the progress of therapy and can respond positively with medication.

The following are medications commonly used with MPD patients: (Kluft, 1991b)

1) Hypnotics and sedatives – for sleep disturbance. Often caused by alter activity during the hours of sleep.

2) Minor tranquilizers – for anxiety. Sometimes major tranquilizers are used when tolerance has occurred, but generally should be avoided.

3) Tricyclic antidepressants – for depression. The therapist must be cautious in prescribing, due to patient's self-destructive impulses. Monoamine oxidase inhibitor (MAOI) drugs may be used but should be given special attention in regards to the self-destructive patient and used judiciously.

4) Lithium – for patients with co-existing bipolar disorders.

Loewenstein (1991) recommends the following guidelines for the pharmacotherapy of MPD:

Rule 1: Use of medications for MPD patients must be understood in the context of the total treatment of MPD.

He suggests performing a thorough medication history of the patient with regards to adherence to therapeutic regimes and liability to self-destructive acts. The clinician must determine liability to self-destructive acts. The clinician must determine that the potential benefits of medication outweigh the potential risks. He recommends finding nonpharmacologic interventions for symptoms. For example, if anxiety is the result of conflict among alters, then psychotherapeutic methods should be the primary focus.

The entire system must e enlisted in the cooperation with a pharmacologic regime. If one or more alters is absolutely opposed to medication, then this treatment must be withheld until agreement is obtained. The clinician must then work with the opposing alters to establish the reasons for non-compliance, which may be grounded in the childhood trauma. Many MPD patients report the use of drugs during abuse to assure the victim's compliance. Certain alters ay have valid fears and resistance to the use of drugs in treatment and these issues can be worked out in psychotherapy and/or hypnotherapy. The system needs to agree to take the medication as prescribed, to use it for one body only, to not use it in a self-destructive manner, and to monitor the effects of the medications.

Determination of a clear response to medication can be quite difficult in MPD patients. One reason for this is the obvious, the various alters may respond differently to medication. Also, with the bombardment of stress incurred in a clinical setting, through the recovery of memories, telling the secrets, and exposing the hidden alters, the symptoms produced can be so overwhelming as to obscure any small positive response to medication.

To highlight the difficulties of working with the system to cooperate with a medication regime, Loewenstein gives the example of a patient given imipramine for major depressive disorder witnessed in the host personality. The host soon reported feeling improved with no negative side effects from the medication. Within the same session several other alters came forward with different reports of either no benefit from the medication, or terrible side effects, and finally an adolescent alter who admitted to not taking the medication at all, but that she was stashing the pills away to use in a suicide attempt. It was then established that the patient had, in fact, not taken a single dose of the medication.

Rule 2: Most problems in the treatment of MPD are not solvable with medications.

During the course of treatment for MPD a myriad of problems, crises and symptoms will arise. Loewenstein maintains that these are not caused by disorders or processes which are responsive to medication. Instead, they are caused by conflicts among the alters, a hidden traumatic memory, a current life problem, or passive-influence. He maintains that these are treatable through psychotherapeutic and/or hypnotherapeutic measures, rather than medication, He suggests the clinician begin by doing a thorough system search for the source of the symptom, and to assess to what extent it affects other alters.

Rule 3: (A) One must attempt to treat symptoms in MPD that are valid psychopharmacologic targets. (B) Insofar as possible, one must attempt to target symptoms that are present across the "whole" human being, not those localized in separate alters.

- Psychotic-like symptoms – True psychosis in MPD patients is rare. If the patient appears to have psychotic symptoms it is generally due to the interactions of the alters. If a patient responds to neuroleptics, it is usually due to the abatement or severe anxiety caused by intense internal conflicts between the alters. Loewenstein suggest that, due to the many adverse side effects of neuroleptics on MPD patients, it is preferable to try nonpharmacologic interventions or other psychotropic agents.

- Affective symptoms – Mood shifts in MPD patients are usually caused by rapid switching between alters, the recall of traumatic material into consciousness or the overlap of alters with different levels of activity. Loewenstein states these mood shifts are much more rapid than the most rapid-cycling bipolar patient.

- Somatoform symptoms and pseudoseizures – Some common somatoform symptoms are chronic pain such as headache, abdominal and groin pain; paralysis, blindness, deafness and pseudoseizures. These somatic symptoms are often due to the encoding of traumatic memories in the body, or body memories. An example of this would be a young woman forced to have anal sex as a child who has recurrent rectal and bowel pain as an adult. The somatic symptoms can also be due to conflicts among alters. Loewenstein recommends avoiding the use of narcotic analgesics and relying instead on the long term work of psychotherapy for a definitive abatement of somatic symptoms.

- Anxiety, Panic, Phobias, and PTSD symptoms – PTSD is the most common co-morbid disorder in MPD patients and one that usually requires definitive treatment. Most MPD patients will show overt symptoms of PTSD during treatment as the amnestic barriers are dropped and the traumatic memories come up. The primary treatment for PTSD inn MPD patients is psychotherapy and/or hypnotherapy. The therapist should help the patient to visualize the memory on an internal screen, create a safe place for upset alters to go, and some kind of imagery to turn down and control the anxiety such as an internal TV volume control. In this manner the therapist helps the patient to work through each memory. Clinical experience with many MPD patents suggests that few derive any beneficial response from tricyclic antidepressants for either PTSD or affective symptoms.

Monoamine oxidase inhibitors (MAOIs) may be more beneficial, however due to the instability of MPD patients they cannot be relied upon to manage the necessary dietary restrictions, thus their use is not recommended. Lithium has not been seen to provide significant benefit, and again the apparent mood swings may in fact be due to internal conflicts among alters rather than true bipolar illness.

Studies have shown the use of propranolo or clonidine to effectively treat the symptoms of hyper-arousal seen in PTSD. (Loewenstein, 1991) Benzodiazepines are often the safest medications to give MPD patients. Clonazepam has also been found helpful in the treatment of PTSD symptoms. Barbiturates and other nonbenzodiazepine sedative-hypnotic medications should be avoided due to their lethality and the high suicide risk of MPD patients.

- Sleep problems – Sleep problems are generally due to switching and activity of alters, nocturnal fugues, nightmares and flashbacks causing frequent awakenings, disorientation, and restlessness. Psychotherapy is recommended, however, benzodiazepines a higher dose of the routine tricyclic antidepressant at nighttime, or anticholinergic drugs can be useful.

- Self-Destructive or mutilating behavior – Naltrexone may be helpful for control of the addictive component of chronic self-mutilation, eating disorders, or compulsive exercise or sexuality. The affects is on the endorphin response to posttraumatic stress. This is still an experimental medication for treatment in MPD patients.

In general, psychopharmacologic treatment of MPD patients is still experimental. Psychotherapy and/or hypnotherapy are the treatments of choice. The clinician must search the MPD system of the patient to determine the source of symptoms, and then treat them accordingly, rather than routinely giving a medication that may have some immediate benefit without long term results.

PROGNOSIS

The prognosis for most patients with MPD is quite optimistic if appropriate treatment is available, (Kluft, 1989b) Though the treatment is long, arduous, and continuous throughout a patient's life, these patients are responsive to intense psychotherapeutic interventions and they do have the ability to live normal, healthy and productive lives. The average length of time from initiation of therapy to stable integration is 21.6 months. (Ross, 1990)

Spontaneous remission cannot be expected in untreated MPD patients. What happens instead of one alter may predominate, with infrequent overt or covert influences by others, particularly as the patient progresses into middle or old age. (Kluft, 1989b) Kluft followed over a dozen MPD patients who declined treatment and over two dozen who entered therapy where MPD was not addressed. Two to eight years later all continued to have MPD. However, of the patients who were appropriately treated for MPD, upon reassessment, these were noted to have made good progress in recovery.

A phenomenon called "layering" sometimes occurs,. This is the process by which groups of alters who have been suppressed begin to appear as the more predominant alters are integrated. (Kluft, 1989b) This could appear to be relapse, and would reinforce the importance of ongoing therapy even after it appears that integration has been achieved.

Seventy-five percent of relapses appear to be the result of object loss, rejection, or the threat of such experiences. (Kluft, 1989b) If a patient continues therapy after integration and has developed a good support system, perhaps including an after-care group, he or she will better be able to deal with these crises as they occur, and possibly avoid the self-destructive behavior that leads to hospitalization.

NURSING IMPLICATIONS

The confines of a hospital setting, with its rules and limits, can be quite threatening to MPD patients. It can feel like a re-enactment of the childhood trauma, with the nursing staff that enforces the rules playing the role of abuser. The patient will subconsciously assign trauma-related roles to staff and will react to them accordingly.

Certain alter personalities in particular may have a difficult time in the hospital. Child alters can be disruptive. Limit settings can bring out the anger of a protector. Alters may hide when they feel threatened, and the risk of elopement is high whether volitional or while in a fugue state. An alter may even present as stable enough for discharge in an effort to escape from the demands of a hospital setting.

Primary to the nursing role in working with MPD patients is creating an environment that is supportive accepting, and protective. Establishing trust is imperative and is facilitated through consistency and honesty in dealing with the host and all alter personalities. Alters are encouraged to come out in an environment which feels safe, accepting and empathetic.

Nursing responsibilities include:

1) Provide a safe environment, protecting the patient from the self-destructive impulses which arise during therapy and from hostile alter personalities.

2) Provide an environment of acceptance and support.

3) Provide an environment for socialization.

4) Support the patient in acceptance of the disorder.

5) Provide consistency in treatment.

6) Assist patients in learning new coping skills as they interact within the milieu.

It is important for nursing staff to continually observe and evaluate for potentially self-destructive or violent behavior and to intervene to keep the patient safe. Getting the patient to contract for safety may need to be done each shift and with all alters. Staff must insist upon assurance of safety and control from the patient and if the contract is not convincing or does not appear to be an agreement of the entire system, then suicide precautions should be implemented.

Nurses have an important role in ongoing observation and evaluation. Staff can observe what stressors bring out certain alters and what their functions seem to be. This is a valuable adjunct to the psychotherapy session. Where the therapist has only one hour to observe alter activities, nursing staff has the opportunity to observe around the clock.

As patients begin to break through amnestic barriers related to the childhood trauma they become more and more dysfunctional. They may feel exhausted and hyper somnolent, or energized and hyperactive. They can also become confused around identity. Nursing staff can help patients to focus on concrete tasks of daily living and problem solving. This helps the patient feel safe,, secure and contained at a time when everything seems out of control.

Nursing staff can help the patient become involved in activities such as art or writing projects which can be used to introduce the different alters to each other, and offer proof to the host of the existence of other personalities. The artwork or writing can help define who the alter is and what his or her purpose is in the system.

When patients show signs of behaviors or somatic symptoms that might suggest the need for medication, nurses should remember that MPD patients respond better to psychotherapy than to medications for certain symptoms and behaviors. (Kluft, 1991b) For example, what may appear to be hallucinations or quasi-psychotic behavior may in fact be the inner noise of the system; or a severe headache may be due to the conflict of one particular alter. The nurse can call out the alter or alters who are experiencing the problem, encourage them to talk about the conflict and therapy resolve the symptoms.

However, if medication does become necessary, it is wise to ask an adult alter, preferably the host, to come out and take the medication. Staff should mentor the patient’s responses to medication, and particularly the different alters responses.

Because of the general chaos of the personality system, as well as the borderline characteristics demonstrated by many MPD patients, it is necessary to have a treatment plan tht is clear to the entire treatment team. This will provide consistency to the patient and cohesiveness among staff.

The following are guidelines for hospital treatment of MPD patients:

1) Make it clear to the patient that the staff is not expected to recognize each alter. Alters must identify themselves to staff and it is appropriate for staff to ask the patient the name of the alter who is out. Nurses are not expected to change their own

behavior according to the alter they are speaking to. This may anger or frustrate the patient, who wants each alter to be regarded as special and recognized as a separate entity. However, they must understand that to outsiders, many alters in the system look the same and that in society people will not change their behavior to respond as the system switches. Also, nurses should not assume that because they are known to the host or certain other alters, that the entire personality system knows them. Meeting each personality is like meeting a new person. Introductions need to be made, trust established, and the milieu regimen explained.

2) Treat all alters with equal respect and address the patient as he or she wishes to be addressed. In this general functioning of the unit the patient should be referred to by the legal name. However, in a more in-depth one-on-one conversation, the patient may be called by the name of the particular presenting alter. Complete abandon of social conformity is regressive and strict adherence to the use of the patient's legal name only serves to set up a power struggle as the alter attempts to demonstrate his or her separateness and specialness. (Kluft, 1991b)

3) Staff crises are to be expected. The therapist should be available for supervision and problem solving.

4) Explain hospital rules and ask all alters to listen and comply. If problems of compliance occur, respond with firm yet caring limits. Punitive measures are to be avoided. Too much limit setting and too much intimacy should be avoided. A professional, caring attitude is appropriate. Let patients know that they are expected to attend activities in alters who are appropriate for the occasion, who can participate and conform to the limits of the situation. A child alter who comes out during group therapy and wants to pay would be invited to leave the group and play in her room. T is not a necessary part of treatment for alters to appear at random and be allowed to disrupt or control the milieu by their erratic behaviors.

5) Encourage non-verbal groups, such as art, music, or movement.

6) Maintain cooperative therapeutic goals among staff. A consistent approach and attitude are extremely important.

7) Help the patient to stay focused on the goals of treatment rather than become distracted by problems in the milieu.

8) Clarify the various roles of staff members to the patient so that he or she does not become confused or perceive a staff member as uncaring for not working with them as someone else did. For example, the psychotherapist will work with each alter in depth, and may not wish for nursing staff to do the same. Explain to the patient the role of nursing so he or she will not have the same expectations of nursing staff as of the psychotherapist.

Techniques for Managing Dissociative Crisis
(Parsons, 1989)

Switching, in and of itself, is not an indication of decompensation or crisis. An alter is generally out for a reason and nursing staff can reassure the patient of this. Staff need not be alarmed by switching behavior. Rapid switching might be a sign of a great internal struggle and the therapist should be notified in such cases.

It is generally not the role of nursing staff to uncover alters or work in-depth with them on issues. When possible, it is appropriate to encourage the patient to delay such work until he or she meets with the primary therapist.

Nevertheless, there are times when nursing staff are confronted with the memory work, and must take measures to assure successful management of such crises. The first attempt should be to contract with the alter who has the memory to wait for the therapist. Imagery, such as putting the memory in a box and leaving it on a shelf until the next meeting with the therapist is sometimes easily accomplished due to the patient's high degree of suggestibility.

If the patient is unable to delay the emergence of the memory, the nurse can help with the abreaction. The nurse should remain calm and insure patient safety by removing the patient to an area designated for such work (e.g. usually an unfurnished room with pillows and carpeting where the patient can have privacy; often called a quiet room or safe room). Notify her staff in case assistance is needed as the patient abreacts. The nurse calls on the alters who need to be present to do this work, while others are asked to go far away. Any physical contact, such as holding the hand or touching a shoulder, should only be done with the patient's approval. As the memory unfolds, the nurse asks the patient to talk. If the patient is unable to talk, ask if it is alright to interpret, and suggest the patient indicate a correct interpretation by the use of hand signals (e.g. index finger for yes, thumb for no).

At the completion of the memory, the nurse summarizes the experience as valid and painful, and that the child was not responsible for the experience; it was the sick and dysfunctional adults who were responsible. The child is not to blame and is not bad. It is then reinforced to the patient that the experience took place in the past and although it was terrible, it cannot harm him or her today. Encourage the alter to go to a safe place and recall the host.

If it appears the patient's behavior is threatening to become self-destructive or other-destructive, the nurse must act quickly to control the situation. The out of control alter can be counted down by the nurse into a safe place. The nurse counts out loud 5-4-3-2-1. The system is then asked to call up an alter who can handle the present situation and keep everyone in the system safe. The nurse counts out loud 1-2-3-4-5.

These experiences can be unnerving, but after working with a patient consistently the nurse will find it easier to assess when a crisis may occur and how to prepare for it. Staff will also gain an understanding of how a particular patient responds to crisis and to the above

techniques. It is often surprising to nursing staff how susceptible MPD patients are to suggestions and prompts. In this, their behavior is much more easily handled than in many other psychiatric manifestations.

BORDERLINE PERSONALITY DISORDER BEHAVIORS

It is important for staff to remember that the MPD patient looks at the world and all experiences from the position of the traumatized child. Kluft suggests that more MPD patients are "borderline in appearance than in fact." (Kluft, 1991b) Attention to limit-setting and establishment of boundaries is of primary concern to nursing staff with this group of patients who can be particularly manipulative and provocative. Staff should be aware of the patient's attempt to split staff, should try at all times to work together cohesively, and not allow the patient to manipulate favorite staff members.

Even if the patient does not actively participate in the split, nursing staff can become split by their own different feelings and beliefs about this very controversial disorder. Staff members will have vast differences in level of empathy and believability, and their ideas for treatment can be quite different. It is important to have and maintain a treatment philosophy, goals and methods so that the patient experiences consistency among the staff. Since these patients grew up with inconsistent and confusion messages from their families, it is imperative not to re-create a split and confusing picture for them in treatment.

It is helpful to remember that current behavior is predicated on a past wherein the traumatized child's ability to use his or her own wits to rise above a situation meant survival in a hostile environment. MPD patients are constantly evaluating their environment for the changes they are sure exist and working within their detailed framework of alter personalities to outsmart the situation. Most MPD patients will interpre4t even the most gentle limits as punitive. This is where nursing staff can help the patient learn new ways of dealing with the world. Nurses can help the patent to understand the source of anxiety or panic, to see how it relates to past experiences, then to see the current situation as different and chose to respond differently to it.

There are theoretical differences between the splitting behavior of the borderline patient and the MPD patient. The borderline patient is testing staff investment and acting out unfinished business with mother. For the MPD patient, however, the behavior can be related to the varying attitudes of different alter personalities, and an inability to separate here and no from then. (Parsons, 1989)

STAFF NEEDS

MPD patients can cause anxiety, frustration and anger in nursing staffs for a number of reasons. MPD patients are often experienced as to overwhelming that it threatens the sense of competence of the staff. The sense of helplessness that the staff may feel an create a negative response toward the patient,. This especially happens if the staff has not be adequately educated or prepared in understanding MPD and how to work with such patients, and if the hospital has no particular policy or treatment modality for these patients. Staff may become angry with the

therapist whom they feel has left them to deal with the overwhelming behavior. Hospital staffs are often split in their feelings about MPD. Credibility is an issue. Kluft feels that thought MD patients certainly do demonstrate the borderline quality of splitting a staff, staffs more often split themselves by their own differing feelings and opinions about the disorder. Because of the MPD patient's sensitivity to the feelings of others they will they will necessarily withdraw from staff they feel rejected by and gravitate to those they find accepting. This will add to the polarized stance of staff members. Kluft also suggests that, because nurses may feel unprepared to deal with the MPD diagnosis, they may resort to treating the MPD patient as if his or her psychopathology is one the nurse is more familiar with, such as psychosis or borderline personality disorder. (Kluft, 1991b)

Kluft suggests that it is not necessary for nurses to come to a collective agreement about their feelings of MPD, or that it is necessary to convert those who don't believe. What is necessary is for the clinician to establish goals of admission, clearly convey them to nursing staff, and expect that nursing staff will facilitate the achievement of these goals in a professional manner, despite their personal feelings, In areas of safety, limit setting, getting along in the milieu, appropriate groups and activities, it is not necessary to get in conflict over the believability of MPD.

The constant dealing with traumatic material from MPD patients makes a staff venerable to secondary posttraumatic stress disorder. It is necessary for the staff to have support groups. Supervision must be provided for staff, with an environment conducive to expressing disbelief, frustration, and anger. Treatment goals and methods should be clearly outlined for all staff to follow.

CASE STUDIES

CASE #1

Marrion, a 28 year old woman, was admitted to the hospital by her outpatient therapist who felt at a loss of how to deal with Marion's newly diagnosed multiple Personality Disorder. She had a psychiatric history that began when she was 19 years old. She had been hospitalized twice, both times for suicidal impulses. She had been previously diagnosed with borderline personality disorder. She had also been in therapy with several different psychiatric professionals.

Marrion presented as a frightened, withholding, depleted and extremely depressed person. The name on her insurance identification card was Mary Anne. Marrion stated that Mary Anne had not been seen for many years, that she was incapable of managing "everyone." Marrion was the only person able to keep everything in control, managing work, a husband and day to day living. However, doing this was taking its toll on Marrion. She was exhausted from hr constant vigilance over conflicting alters and the pressure of memories about to emerge, which Marrion was terrified to bring up.

Once settled into the unit, Marrion seemed to almost immediately relinquish control. A child alter, Mimi, was often seen at rambunctious play. Mimi's facial expressions and

movements were markedly different from those of the depleted Marrion. Mimi appeared refreshed, happy, open to everyone, and would run and skip and jump her way around the hospital grounds.

Other alters began to emerge in time. There was Kate, a venerable child alter, who would approach nursing staff at night asking when her mommy was coming home. This alter would also run outside at night and hide in the bushes while she awaited mommy's return. The patient, Mary Anne, had a history of abuse by her father, which included the escape of her mother one night through a window, never to be seen again until the patient reached college age.

An alter, called the Light Watcher, would sit at a window at night, appearing quite morose, and almost evil or dangerous in her appearance of blank inwardness, or calculating muteness. This alter's purpose was not completely understood. But it was apparent her actions also had to do with watching for mother to come home by watching the lights of cars as they would pass by on the street. This alter was viewed as dangerous and unpredictable by Marrion.

Mimi was allowed and encouraged to be out for long periods of time to provide necessary respite for Marrion. Marrion would appear more rested and relieved after Mimi had been out to play. Kate needed to be protected at night from becoming lost or harmed outside. She was comforted and asked to go to a safe place inside and to let Marrion help her to feel taken care of. The Light Watcher was counted down into a safe place as soon as possible upon appearance and asked to make its issues known to the therapist. The therapist was successful in calling up this alter in psychotherapy sessions and working through its evil fascination with revenge and pain. The birth personality, Mary Anne, was never seen during the hospital stay.

By this time in treatment Marrion had made many gains into co-consciousness and communication among her alters. She was also feeling much more rested as she allowed her alters to come out and express themselves, and as she safely worked through memories in the safe and supportive environment of the hospital.

CASE #2

Bonnie was admitted to the hospital for depression and suicidal ideation. She was also diagnosed with bulimia. Bonnie had never before been hospitalized, but admitted to feeling depressed most of her life. She stated she often felt suicidal, but her purge behavior somehow gave her a sense of relief, for which she was quite ashamed. Up to this point she had been working with a therapist around her eating disorder issues, which were a source of great frustration, depression, and negative feelings about herself. Neither she nor her therapist felt she was progressing in therapy. She seemed to be very blocked. Though there was sometimes a hint of child abuse, Bonnie tended to focus on contemporary problems such as relationships, work and her self-image. She was quite adept at steering clear of childhood issues, beyond a rudimentary history of her family of origin.

Bonnie's negative self-image led her to feel like cutting her wrists. She had made some superficial cuts with a butter knife and it was at this point her therapist felt it necessary to

hospital her for protection.

In the hospital, still, it was very difficult to access any material with which to begin work. She continued her bulimic behavior of purging after almost every meal. Her feelings about herself became increasingly more derogatory and she required suicide precautions daily. Finally, it was decided to attempt hypnosis with amytal.

Under hypnosis, a child alter named Shoshana reluctantly came forward. She admitted to feeling extremely frightened. Having to see or eat meat made her vomit because she was forced to eat raw animal flesh as part of cult rituals as a child. She was terrified she would be killed as a result of sharing this information.

In another hypnotic session, the persecutor alter who threatened Bonnie's life if she divulged any information about the past, was finally accessed and worked with in regards to the destructive behavior.

After approximately six weeks Bonnie was able to control the suicidal impulses to the point of continuing productive therapy. She gained some control over her bulimic behavior by changing her eating habits to vegetarian. Though frightened, she experienced a sense of relief over the diagnosis of Multiple Personality Disorder because she finally had a point at which to begin appropriate treatment.

Bonnie's hospital stay was approximately eight weeks. Once she could control the suicidal impulses and trust her inpatient therapist with the traumatic material, she was discharged and continued working with that therapist on an outpatient basis.

CONCLUSION

As can be seen from the text, Multiple Personality Disorder is a difficult diagnosis to make and then to treat. Patients diagnosed with this disorder have already experienced many years of pain and difficulty, and will have years of arduous work ahead of them. Nurses working with such patients will experience the greatest challenges they have ever faced in a psychiatric setting, which can prove to be some of the most interesting and rewarding experiences, as well.

Psychiatric professionals have made much progress in the past two decades in understanding and treating the disorder, and there are still many more gains to be made. Acceptance of this controversial diagnosis is increasing and information made more and more available through controlled studies by the experts. As appropriate treatment is applied to appropriate patients, more success will be documented, thus adding to the credibility of Multiple Personality Disorder.

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TEST

1) The phenomenon of Multiple Personality Disorder was first examined:

   a) Approximately 100 years ago
   b) By the pioneers of psychiatric medicine
   c) In Europe only
   d) A and B

2) Multiple Personality Disorder (MPD) occurs:

   a) In women only
   b) B) in 1.2% of general psychiatric population
   c) About as frequently as schizophrenia
   d) B and C

3) The increase in attention to MPD and reported cases since 1970 is attributed to all but the following:

   a) An increased awareness of child abuse
   b) More individuals have MPD now than at any other time in history
   c) More objective and sophisticated case studies and investigations

4) All but the following is true of dissociation:

   a) It is a coping mechanism that develops when normal coping mechanisms are depleted.
   b) In this state the individual withdraws consciousness while the brain encodes information about the event in a fashion that reduces the shock to the individual.
   c) The individual is conscious of doing this and is able to perform it at will
   d) The result of dissociation is that the event is not completely experienced by the individual.

5) The most extreme level of dissociation is called:

   a) Posttraumatic Stress Disorder
   b) Multiple Personality Disorder
   c) Hyper-Dissociation
   d) Borderline Personality Disorder

6) Which of the following is true of Multiple Personality Disorder:

   a) It is the result of trauma which is far greater than normal human stress and surpasses the individual's ability to cope
   b) The trauma causes the young developing mind to fragment into different selves
   c) A separate consciousness, or personality, is developed which stores the traumatic information
   d) All of the above

7) MPD begins:

   a) In adolescence
   b) In adult women, between the ages of twenty and forty
   c) In childhood, between the ages of two and eight

8) A history of childhood physical or sexual abuse:

   a) Is found in 97% - 98% of MPD cases
   b) Is a minor factor in the etiology of MPD
   c) Is found to be traumatic, but not sufficient to cause MPD

9) The individual with MPD:

   a) Is completely aware of the other personalities
   b) Has a very dramatic presentation with obvious switching between personalities
   c) Often has a very subtle presentation, where switching is apparent only to those who know the individual well

10) The higher percentage of reported cases among females is most likely due to:

   a) A higher incidence of childhood abuse among girls than boys
   b) Women tend to respond to emotional trauma by performing harmful acts against themselves, which leads them into treatment
   c) Men tend to respond to emotional trauma by performing acts of violence against others, thereby ending up in the criminal justice system
   d) B and C

11) The severity of dissociation is related to:

   a) The age of the individual when the abuse experience began
   b) The relationship of the abuser to the child
   c) The frequency of the abuse
   d) All of the above

12) With depersonalization:

a) The person has the feeling they are an outside observer to themselves
b) Fears they are going insane
c) Must practice taking things less personally
d) All of the above
e) A and B

13) Which of the following is not true of depersonalization?

a) The child is able to absolve him/herself of the guilt surrounding the abuse by experiencing the event as happening to someone else.
b) It is not helpful to the child experiencing the abuse.
c) It allows the child to continue to live in the abusive environment without emotional collapse.
d) It is seen as a helpful coping mechanism for the child at the time of abuse, but a problem in later adult life.

14) Multiple Personality Disorder:

a) Is at the furthest extreme of the continuum of dissociation
b) Is characterized by sudden, unexpected travel away from home
c) Is often associated with victims of cult abuse
d) A and C

15) An <u>average</u> number of personalities for someone with MPD:

a) Ranges from eight to thirteen
b) Is usually well over 100
c) Increases as the person ages

16) The various personalities:

a) Are experienced by the individual as separate and distinct entities.
b) Share the same memories and feelings about the abuse experience
c) Have been created to perform different functions or roles in the person's life
d) A and C

17) The host personality is:

a) The personality who has executive control of the body the greatest percentage of time
b) May or may not be the legal personality
c) The personality perceived by the system as capable of keeping the system intact.
d) All of the above.

18) The presenting personality is:

a) The same as the host
b) The personality who presents for treatment
c) Is only experienced during the first contact with a therapist, then disappears.

19) The most common personality found among MPD patients is:

a) The presenting personality
b) A nurturing parent figure
c) A terrified child
d) An animal

20) Co-consciousness refers to:

a) The ability to go into a hypnotic trance
b) The awareness of one personality to the others
c) The ability to remember the abuse

21) Switching can be brought on by:

a) Vague memories of abuse
b) Stress in the individual's life
c) Conflict between the alters
d) All of the above

22) Protective personalities:

a) Are always male
b) Are of very little use in therapy
c) Were created to protect the original or other personalities from intolerable conditions.

23) The internal self-helper personality:

a) Is the rational part of the system
b) Is extremely helpful in therapy
c) Is able to assist the therapist in working with the various alters
d) All of the above

24) The manifestation of the various alter personalities can seem fantastic and unbelievable. It is important to:

a) Give the patient a reality check and lt him or her know that these personalities do not really exist.
b) Remember that to the patient each personality is a separate and real entity and must be given respect as such.
c) Tell the patient they no longer need these alters and to stop switching.

25) Prior to receiving an accurate diagnosis and appropriate treatment, the average MPD patient:

a) Receives three erroneous diagnoses
b) Usually ends up in jail
c) Has spent up to 50% of his or her life in a hospital
d) All of the above

26) Diagnosis of MPD is made difficult by:

a) The secretiveness of these patients
b) The existence of concomitant behaviors and disorders
c) Cycles of overt versus convert behavior
d) All of the above
e) None of the above

27) The amnesia which exists in MPD is due to:

a) A head injury
b) Drug and alcohol abuse
c) Alter activity and an absence of co-consciousness
d) All of the above

28) Which of the following are signs and symptoms of MPD?

a) Body memories
b) Periods of amnesia, particularly of childhood
c) Objects in one’s possession which cannot be accounted for
d) All of the above

29) The most common differential diagnoses of MPD are:

a) Borderline personality disorder and depression
b) Borderline personality disorder and schizophrenia
c) Schizophrenia and anti-social personality

30) The difference(s) between schizophrenia and MPD is/are:

a) Schizophrenics hear voices outside the head most of the time, and MPD patients usually hear them inside the head
b) Schizophrenics have an intact sense of reality and MPD patients do not
c) A and B

31) Which of the following are considered appropriate diagnostic tools for diagnosing MPD?

a) Suggesting the patient write in a diary thirty minutes per day.
b) Direct questioning about traumatic events
c) Hypnosis
d) All of the above
e) A and C

32) Classic MPD is described as:

a) A patient with at least 15 alter personalities.
b) Overt behavior that fits the diagnostic criteria for MPD on an ongoing basis for periods of months, years, or even a lifetime
c) The disorder first studied by psychiatric pioneers one hundred years ago.
d) All of the above.

33) Possession form MPD:

a) Is a variant form of MPD where the most evident alter presents as a demon or devil.
b) Can easily be mistaken for psychotic conditions.
c) Is a form of MPD where the patient is obsessive about his or her possessions.
d) A and B

34) Covert MPD:

a) Is the form most characteristic of patients with MPD.
b) Is characterized by patients who feel as though their lives are out of control and that their actions are imposed upon them by a power unseen.
c) Includes such forms as Phenocopy and somatoform MPD
d) All of the above

35) Pseudo False Positive MPD:

a) Was commonly seen one hundred years ago and is not uncommon.
b) Is not true MPD.
c) Was used as a desperate attempt of the patient to convince the clinician of the presence of MPD.
d) Is only seen in patients born in the 1970's and 1980's.

36) The various alters can create difficulty in treatment by:

a) Continual switching
b) Harming another alter for sharing information
c) Withdrawing the patient from therapy
d) All of the above

37) In a double-bind set up the patient:

a) Sets up situations to cause the therapist to appear abusive or uncaring.
b) Is to perform certain tasks for diagnostic tests
c) Will test the therapist's trustworthiness
d) All of the above.

38) Braun's 13-Point approach to treatment includes:

a) Medication, integration, graduation
b) Communication with alters, contracting, new coping skills
c) Solidifying skills, follow-up, termination of therapy
d) All of the above.

39) In Resolution and Integration:

a) The patient's heightened sensitivity allows for greater coordination of body movements
b) The patient is ready to terminate therapy
c) Personalities blend rather than continue power struggles.
d) The patient learns new ways of coping with stress.

40) Though the goal of treatment is integration, sometimes all that can be achieved is:

a) Helping the patient to find a support group
b) To eliminate the conflict between personalities so that they can work collaboratively.
c) For the patient to be aware of the diagnosis of MPD

41) Integration is described as three stable months of:

a) Continuity of contemporary memory
b) Absence of overt behavioral signs of multiplicity
c) Absence of alter personalities on hypnotic re-exploration
d) All of the above.

42) The recommended treatment of choice for MPD is:

a) Biofeedback
b) Behavior modification
c) Psychoanalytic psychotherapy
d) Freudian analysis

43) Hospitalization of the MPD patient is sometimes required:

a) To protect the patient from harmful impulses
b) To access memories from reluctant alters
c) To receive support from other MPD patients
d) All of the above
e) A and B

44) Group therapy is generally contraindicated for the MPD patient because:

a) They are very sensitive to the issues of others
b) They can become overwhelmed and disrupt the group
c) MPD patients don't like group therapy
d) A and B

45) Abreactive therapy:

a) Employs hypnosis to guide the patient back into a memory and to re-experience it as though it were actually happening
b) Is a dangerous technique
c) Is the process of assisting the alter personalities to communicate with one another.
d) All of the above.

46) Medication should be used:

a) To treat the core psychopathology of MPD
b) To treat the co-existing symptoms and conditions which interfere with the progress of therapy.
c) Never with a MPD patient
d) To prevent the patient from switching

47) Primary to the nursing role in working with MPD patients is:

a) Playing the role of the abuser
b) Creating an environment that is supportive, accepting, and protective
c) Helping the patient to re-enact the trauma
d) Enforcing strict rules and limits

48) When switching occurs:

a) Nursing staff should be alarmed and notify the physician immediately.
b) Offer the patient medication
c) Nursing staff need not be alarmed and can reassure the patient that the alter is out for a reason
d) Work with the patient using abreaction techniques.

49) In a dissociative crisis the nurse can help the patient by:

a) Insuring patient safety
b) Notifying other staff in case assistance is needed
c) At the completion of the memory, summarizing the experience as valid and painful.
d) All of the above.

50) If the patient's behavior threatens to become out of control, the nurse should:

a) Count down the out of control alter and count up an alter who can keep the system safe
b) Call for security immediately
c) Give the patient a tranquilizer STATE
d) Put the patient in restraints