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Brief Reports

Multiple Personality
A Symptom of Psychiatric Disorder

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A case is reported of a young woman presenting with symptoms of so-called multiple personality disorder. It is proposed that this condition should be viewed as a non-specific psychiatric symptom.

Interest in so-called multiple personality disorder (MPD) has waxed and waned since the first description of a case by Mitchill in 1816. Two British cases were reported soon after this (Mayo, 1845; Skae, 1845), and by the turn of the century a wave of interest followed the demonstration of the remarkable effects of hypnosis. A renewed enthusiasm for the diagnosis has been evident since 1970. Bliss (1986) estimates that of the 300 case reports in the literature, at least 79 were reported in the decade after 1970, in contrast to the eight cases reported in the previous decade. Almost all of these reports have come from North America, where recent sensational biographical accounts of patients also originated (Thigpen & Cleckley, 1957; Schreiber, 1973; Hanksworth & Schwarz, 1977; Keyes, 1981). In the past 20 years only one case report has appeared in the British literature (Cutler & Reed, 1975). British psychiatrists have been sceptical of the validity of the diagnosis, echoing critics from the nineteenth century who believed that these patients were clever, manipulative or suggestible 'mythomaniacs' (Ellenberger, 1970). However, following the example of DSM-III, MPD will achieve recognition as a separate diagnosis with operational criteria in ICD-10 (World Health Organization, 1987), where it will be classified as one of the dissociative disorders of memory, awareness and identity. In the light of increasing interest in the disorder, doubts about the validity of the diagnosis, and the wide disparity between the American and British literature, we report the case of a woman presenting at the Maudsley Hospital who fulfilled these diagnostic criteria.

Case report

Personal history

The patient was a 31-year-old single Caucasian woman. Her parents were in good health and there was no family history of psychiatric illness or epilepsy. She described her mother as defensive and irrational and her relationship with both parents was poor.

According to her mother, the patient was perpetually frightened as a child. She did well academically at school until she was 14, when the family changed address. At this time she became increasingly anxious, refusing to attend school, and she was assessed by a school psychologist. She had always been shy and made few friends during her school days.

The patient reports that she was sexually assaulted by an uncle and a stranger when she was seven years old. Her recollection of the incident was patchy and at times she has been unsure if the assault took place. Her mother had no knowledge of the incident.

She left school at 15 years of age without taking examinations, but received home tuition for a short time. She worked briefly as a shop assistant when she was 16, and commenced three years of full time voluntary work when 23. After this there were no periods of paid work for longer than one week but she continued irregular charity work, including work with epileptic children. She lived at home until she was 26, when she moved into an epilepsy hostel, and she obtained a flat of her own three years later.

Menarche was at 15 years. She is bisexual but prefers women. She has had several short-lived relationships with both sexes, including some sexual contact, but she has never had sexual intercourse.

Previous medical and psychiatric history

At the age of 15 she was admitted to a psychiatric hospital following the first of many overdoses taken before she turned 18. Most of these parasuicides followed arguments with her parents. She was treated with antidepressants, ECT, minor tranquillisers and hypnotherapy before she was 19. Her local psychiatric hospital 'blacklisted' her when she was 20. She described blackouts since 14 years of age, with visceral and olfactory aura followed by a sudden loss of consciousness lasting a few minutes. She bit her tongue but was never incontinent during the attacks. She was treated with phenytoin and phenobarbitone, with some reduction in the number of attacks. At 20 years of age she was investigated for an 18-month history of unsteadiness and clumsiness, but no abnormalities were detected. Between 20 and 25 she was reasonably well, and did some regular work. After leaving home she recommenced taking frequent overdoses and the number of blackouts increased, leading to her admission to the National Hospital for Nervous Diseases for investigation. Many seizures were observed and were thought to be non-epileptic, leading to the discontinuation of anticonvulsants. Subsequently, she was referred to the Maudsley Hospital and continued to take frequent overdoses until a brief admission for assessment.

At 27 years of age she complained of depression, poor sleeping, losing track of time, depersonalisation and derealisation. She also mentioned hearing angry voices and

she stated that a robot took over her body when she was unable to cope. She said that it was like "an internal mother" and she wanted to destroy it. She later said that she saw the robot and the voices as parts of her own personality. She gradually improved without medication.

She has been seen regularly in the out-patient department since her referral. She has presented to the emergency clinic on many occasions complaining of depression, anxiety, concern about her weight, and suicidal thoughts. These episodes are usually short-lived and she has responded to brief admission. During two of her admissions she had some biological symptoms of depression and at these times she appeared to benefit from antidepressants. She has remained socially isolated, declines to attend a day centre but pays weekly visits to the Samaritans for counselling.

On two occasions this patient has presented with a history suggesting multiple personality disorder. At 28 years of age she attended the emergency clinic saying that she needed to talk to a doctor. The interview consisted of two parts, one where the patient presented her usual character and another where she introduced herself as Anna, a young girl living inside the patient. 'Anna' said that she had been upset by a visit to the patient's parents and she needed someone to talk to. The patient appeared to be fully aware of the content of this conversation and added that she felt that people did not understand her problems. The patient did not discuss these problems or present in this manner again until two years later, following a change in her ward doctor (she had requested a female doctor).

During her first interview with the new doctor (MA), she said that there were five people inside her. Joe was a 19-year-old boy who was quiet, good with children and enjoyed gardening. Helen was 17 years old and was the opposite of Joe, lively, outgoing and articulate. Anna was an unhappy six-year-old who had been sexually molested. Jessie was a cheerful nine-year-old. Katherine was a three-year-old who was recovering from a coma. The patient said that she had 'carried' Jessie around for three years, thinking she was dead at first but later realising that she was comatose. Her personalities were able to 'come out' and take over her body and mind and behave as individuals. She said that each of these 'personalities' was like a part of her own personality, but they were also separate and she knew them as individuals. The personalities had been present for five years; Joe and Jessie had come first. They talked among themselves and sometimes addressed the patient or spoke about her in the third person. Occasionally Helen did things which the patient did not like, such as showing off or irritating other people. Under Anna's influence she had recently visited a toy shop and bought a teddy bear. When the patient was asked by the interviewer to introduce one of these personalities the character of Jessie appeared, speaking and behaving like a young child.

The patient said that she went to the film 'The Three Faces of Eve' and read the book *Sybil* one year after the onset of these experiences, and realised then that they were likely to be symptoms of multiple personality disorder. The patient said that she would prefer to integrate all of these personalities. She denied any psychotic symptoms, depression or suicidal ideas.

On direct questioning she said that she had occasionally experienced periods of lost time; once she thought she had spent the evening sitting down but was surprised on getting up to find that the flat had been tidied, the bed made and a meal prepared. On another occasion she realised that she had lost all recollection for the events of a previous day when a woman asked her questions which implied that she had spent some time at the Samaritans.

The patient presented consistently in this state at several interviews over a four-month period. A decision was made, in the light of her previous psychiatric history, to avoid concentrating on the alternate personalities. This plan was followed and the patient, remaining off antipsychotic medication, became less preoccupied with her other personalities but continued to attend to the out-patient department for supportive counselling. Her case was considered by the psychotherapy unit, who considered her unlikely to benefit from therapy in view of the severe nature of her disturbance and her doubtful motivation.

Investigations

Physical investigations were normal. The patient's score on the Dissociative Experiences Scale (Bernstein & Putman, 1986) was 37 (average 4.38 for normal controls). Although seizures have become infrequent, an EEG was repeated; she had an attack during the testing but there was no evidence of epilepsy on the trace.

Discussion

The DSM–III criteria for diagnosis of MPD are as follows (American Psychiatric Association, 1980):

A. There exist within the individual two or more distinct personalities, each of which is dominant at a particular time.
B. The personality that is dominant at any particular time determines the individual's behaviour.
C. Each individual is complex and integrated, with its own unique behaviour patterns and social relationships.

This patient fulfilled these criteria, accepting the difficulty in establishing when a personality is sufficiently complex to fulfil criterion C. These criteria have been justly criticised as unelaborated and open to a wide range of interpretation (Ludolph, 1985). In order to establish if this patient resembles recently reported American cases, it is relevant to compare her with those described by Putnam *et al* (1986), who have given a detailed description of the syndrome based on a survey of clinicians treating 100 cases. Their study reported that 92% of patients were female, the period from first psychiatric contact to the diagnosis of MPD averaged 6.8 years, and the average age at diagnosis was 31.3 years. The most common alternate personalities were children; episodes of amnesia were reported in 98%; suicide attempts were made by the majority of patients; and 95% of patients had received one or more psychiatric diagnoses

prior to the diagnosis of MPD, most commonly depression, neurotic disorder and personality disorder. A history of significant childhood abuse was reported in 93% and sexual abuse was reported in 83%. Somatic symptoms were also noted to be common, and seizure-like episodes were reported in more than 10% of cases.

The history and psychopathology of this patient have many features in common with those cases reported by Putnam *et al*. She has a marked dissociative tendency, as evidenced by the history of pseudo-seizures and amnesic spells, and finally by her presentation with MPD. This facility with hysterical dissociation appears to be at the root of MPD, but it is clear that the dissociation of personality is but one of a repertoire of dissociative symptoms which these patients exhibit. The non-specificity of the diagnosis is further highlighted by overlap between the diagnosis of MPD, borderline personality disorder (Buck, 1983; Clary *et al*, 1984), and Briquet's syndrome (Bliss, 1986), and by the failure to find a clear pattern of psychiatric diagnosis among the relatives of patients (Putnam *et al*, 1986).

The effects of culture and clinical practice on MPD symptoms is a controversial subject. In the American literature it is evident that once the diagnosis of MPD is made by the clinician, this becomes the primary diagnosis and treatment is focused on reintegrating the personality. The mean length of time in treatment with the reporting therapist in the study by Putnam *et al* was 37.2 months, and 64% were being treated for MPD-related symptoms. In contrast, this patient's problem was seen as secondary to a personality disorder with superimposed dysphoria, and a limited amount of attention was focused on the symptoms of MPD. It is our contention that sanctioning the dissociative behaviour, by concentrating on symptoms or encouraging symptomatic behaviour, may lead to reinforcement and entrenchment of the relevant symptom. This patient expressed her own anger and sadness as the emotions or attitudes of her other personalities. A less dramatic variant, exemplified by Oscar Wilde's claim "I am certain that I have three separate and distinct souls" (Ellmann, 1987), may be a common and non-pathological experience.

As part of her treatment, our patient was encouraged to acknowledge her feelings as part of her own character and to say 'I' rather than to use the name of one of her personalities. She was encouraged to discuss her problems openly, including the experience of sexual abuse. The personality of Anna became less dominant as the patient discussed these problems, lending further support to our hypothesis.

Protagonists of MPD as a distinct psychiatric disorder have failed to produce strong supporting genetic, physiological or epidemiological evidence. However, there is no shortage of evidence which suggests that a long-standing history of poly-neurotic disturbance and personality problems is very common in this group of patients. These difficulties form the foundation of hysterical dissociation of personality and, fascinating as the presentation of MPD may be, it should not distract from the underlying psychiatric diagnosis.

References

AMERICAN PSYCHIATRIC ASSOCIATION (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM-III). Washington DC: American Psychiatric Association.

BERNSTEIN, E. M. & PUTNAM, F. W. (1986) Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, **174**, 727–735.

BLISS, E. L. (1986) *Multiple personality, Allied Disorders and Hypnosis*. Oxford: Oxford University Press.

BUCK, O. D. (1983) Multiple personality as a borderline state. *Journal of Nervous and Mental Disease*, **171**, 62–65.

CLARY, W. F., BURSTIN, K. J. & CARPENTER, J. S. (1984) Multiple Personality and Borderline Personality Disorder. *Psychiatric Clinics of North America*, **7**, 89–99.

CUTLER, B. & REED, J. (1975) Multiple personality: a single case study with a 15 year follow-up. *Psychological Medicine*, **5**, 18–26.

ELLENBERGER, H. F. (1970) *The Discovery of the Unconscious*. New York: Basic Books.

ELLMANN, R. (1987) *Oscar Wilde*. London: Hamish Hamilton.

HANKSWORTH, H. & SCHWARTZ, T. (1977) *The Five of Me*. New York: Pocket Books.

KEYES, D. (1981) *The Minds of Billy Milligan*. New York: Bantam.

LUDOLPH, P. S. (1985) How prevalent is multiple personality? *American Journal of Psychiatry*, **142**, 1526–1527.

MAYO, T. (1845) Case of double consciousness. *Medical Gazette*, New Series, **1**, 1202–1203.

MITCHILL, S. L. (1816) A double consciousness, or duality of person in the same individual. *Medical Repository*, **3**, 185–186.

PUTNAM, F. W., GUROFF, J. J., SILBERMAN, E. K., BARBAN, L. & POST, R. M. (1986) The clinical phenomenology of multiple personality disorder: review of 100 recent cases. *Journal of Clinical Psychiatry*, **47**, 285–293.

SCHREIBER, F. R. (1973) *Sybil*. Chicago: Regnery.

SKAE, D. (1845) Case of intermittent mental disorder of the tertian type, with double consciousness. *Northern Journal of Medicine*, **4**, 10–13.

THIGPEN, C. H. & CLECKLEY, H. (1957) *The Three Faces of Eve*. New York: McGraw Hill.

WORLD HEALTH ORGANIZATION (1987) *ICD-10, 1986: Draft of Chapter V*. Geneva: World Health Organization.

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