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CASE REPORT

Multiple Personality Disorder - A Case Report From Northern India

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Abstract

Multiple Personality Disorder (MPD) has been reported sparsely from the Indian subcontinent. The index case is presented for highlighting its atypical features, which possibly has a determining role in its course and prognosis. These atypical features included the uncommon stress, longer duration of alter state (than host state), and the absence of history of physical and sexual trauma. The case also signifies the utility of short-term behaviour therapy in place of complicated and long-drawn psychotherapies (German J Psychiatry 2005;8:98-100).

Keywords: Multiple Personality Disorder, physical trauma, sexual trauma

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Introduction

Multiple personality disorder (MPD) is a well-known entity. As per ICD-10 (WHO, 1992), it is characterized by presence of two or more distinct personalities within a single individual, with only one of them being evident at a time. Each personality is complete, with its own memories, behaviour, and preferences; these maybe in marked contrast to the single premorbid personality. In the common form with two personalities, the two are almost unaware of each other's existence. Change from one personality to another in the first instance is sudden and is closely associated with traumatic event. Various cases have been reported over the decades from most continents across the globe including India (Verma et al., 1981; Adityanjee et al. 1989). The controversy about its existence continues to prevail. ICD-10 is more sceptical about its existence than DSM-IV (which labels it as dissociative identity disorder) and places it under the category of other dissociative disorders (F44.8). Recent research on phenomenology, epidemiology, psychobiology and treatment support the validity of this disorder. It has been described in adult population as well as among children and adolescents (Putnam FW, 1991; Hornstein NL & Putnam FW 1992; Eldar Z et al., 1997). Prevalence of MPD is reported to be variable from various countries and an approximate 1% prevalence rate has been described in psychiatric inpatient settings (Ross 1991). Among children it is found to be 3% (Hornstein and Tyson, 1991) and 16% among adolescents (Ross, 1996). This article consists of a case report of MPD from Northern India presented for highlighting its atypicalities.

Case History

A 14 years old girl presented at our institute with complaint of 'behaving like a male' for past 2 weeks. She was identifying herself as Mr. S. and dressed herself like a male. She was not recognizing her neighbours, relatives, teachers anymore and her belongings as well. She was not able to recount her personal information too. Her mother also reported a sig-

nificant and contrasting change in her behaviour, like she had become stubborn, confident, outgoing and demanding during this period in contrast to her earlier behaviour. She developed interest in drawing and painting, would demand different types of fast food items, dresses, and articles in the altered state. Her mother fearing worsening of her illness readily fulfilled these demands. Patient had stopped going to school and would stay at home all day long.

On exploration it was learnt that about 2 years back, her father and elder sister had left the house to stay separately from them. There was strained relationship among the parents on the issue of not having a son. Since separation, there was no communication with them. Patient was closely attached with her elder sister and couldn't imagine staying at home in her absence. She would remain preoccupied with her memory and appeared sad and worried. This sadness was not pervasive and persistent and not associated with loss of interest and enjoyment and reduced energy. She would write letters and prepare greeting cards but could not post them, as did not know about their whereabouts. In addition, over the last one year, she started having repeated 'fainting' episodes with twisting of both extremities with no loss of consciousness, major injury, tongue bite or incontinence, lasting for 30 minutes to 2 hours and variable in frequency (once in 10-15 days to 10-15 times in a day). Such episodes continued for another year. Then one morning after an episode she was found in an altered state of male identity with above mentioned behaviour. Since then she would continue to acquire this state recurrently for around 10-15 days and come back in her original state for 1-2 days abruptly. It happened more commonly if there were occasions like her birthday and festivals. She would not have memory of alter state during her original state. There was no history of seizure, trauma and substance abuse. Her birth history and early childhood was uneventful. She was second among five female siblings. She was an average student of VIII grade at the time of presentation. She was described as shy, introvert, sensitive and ambitious. Family history was non-contributory. Physical examination (including detailed neurological examination), CT scan (brain) and EEG reports were found to be normal.

With above findings a diagnosis of MPD (as per ICD-10) was considered and the treatment plan was formulated including drug therapy (anxiolytics) as well as non-pharmacological therapy involving psychological assessment and necessary psychosocial interventions. After several assessment sessions, it was concluded that patient was undergoing severe stress because of separation from her sister. There was no history of physical or sexual abuse elicitable.

Various efforts like announcement at churches across the city were made to trace her sister and to arrange a meeting with her. It was observed that after meeting with her sister, patient resumed her original state and since then she went into the alter state for a maximum of 1-2 hours only (in contrast to the earlier periods of 10-15 days). These residual symptoms were dealt with behaviour therapy. Secondary gains like extra attention and care by mother and fulfilment of extra demands of special foods and various articles during alter state were cut down. Gradually the patient improved and did not go into the alter state till her last follow up.

Discussion

MPD is diagnosed in childhood but typically emerges between adolescence and third decade of life. The female to male sex ratio of DID is 5:4 in children and adolescents (Hocke V, & Schmidtke A, 1998). Most patients with MPD report histories of sexual and physical abuse (Coons PM, & Milstein V, 1986; Putnam FW, 1988). In this case the patient is of *female sex* and the disorder started typically during *adolescen*ce after a stress. She acquired alter states recurrently after a dissociative convulsion and was unable to recall important personal information that cannot be explained by ordinary forgetfulness. In this case there is *no* history of sexual and physical abuse, which is in contrast to the reports from the west. In fact the *stress* in this case is due to parental separation and patient's separation from sister on the issue of her mother not bearing a male child. In some parts of India, more so in North India, male child is viewed as security for future of family. Not having a son is considered as a major stress among couples in Indian culture, which leads to separation, divorce and remarriages of male partners. In this case patient acquires a male identity possibly to overcome the stress. Commonly it is noted that person would remain in host state for longer period than alter state. But in this case she remained in alter state more than that of host state, which can be explained by the fact of continuous nature of stress. In this case alter and original (host) states were of male and female respectively which may be explained by specific nature of stress in the index case.

A differential diagnosis of depression, epilepsy and trance possession syndrome was entertained. Absence of persistent mood changes and loss of interest and enjoyment and reduced energy ruled out depression. Clinical picture, normal CT and EEG records did not favour diagnosis of epilepsy. The alter states in this case could be differentiated from trance possession states, as patient was not aware of her immediate surrounding and her true identity during these attacks and did not remember about these episodes in normal periods. During possession periods, patient remains apparently conscious of his/her immediate surroundings and maintains an awareness of his/her true identity. Patient is also aware of his past episodic possession during the period when he/she is not afflicted. The personality assumed is always that of a concrete known person or a deity whose characteristics are socially agreed upon.

For management we have successfully applied short-term behaviour therapy and environmental manipulation in place of traditional methods of psychological interventions. We believe that long drawn insight oriented psychotherapy may not be required in cases of acute onset and short duration of illness with absence of severe stress of childhood sexual or physical abuse.

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