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Case Report

Multiple Personality Disorder : *A Case Report*

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Summary

Multiple personality disorder (Dissociative Identity Disorder) is rare in Bangladesh but more common in North America and Europe. A medical student was admitted in the psychiatry department of the Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka. He was diagnosed as a case of Dissociative Identity Disorder. The patient was discharged as he improved after anxiolytic medication and psychotherapy. This case is presented here for sharing knowledge with others.

Introduction

Most persons see themselves as human being with one basic personality. Persons with Dissociative Disorders however have lost the sense of having one consciousness (personality). They feel as though they have no identity. They are confused about who they are, or they experience multiple identities[1].

Dissociative Identity Disorder is the name that DSM (Diagnostic and Statistical Manual) uses for what has been commonly known as Multiple Personality Disorder according to ICD (International Classification of Diseases)[1, 2, 3].

There are differences in the classification of Dissociative Disorders in DSM-IV- TR (Diagnostic and Statistical Manual Text Revision) and ICD-10(tenth revision of International Classification of Diseases). In the DSM-IV TR, Dissociative Disorders are categorized separately where as, in ICD-10; Dissociative Disorders are included as a sub category of Dissociative (conversion) disorder [2, 3]. The Dissociative Identity Disorder in the

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DSM system is one of the five subcategories of Dissociastive disorders.

Persons with Multiple Personality Disorder have two or more distinct personalities or identities within themselves, each of which when present may dominate person's attitudes, behavior, and self-view, as though no other personality existed[1, 3].

Many researchers found difficulties to categorize Dissociative Disorders with the existing categories of DSM-IV and ICD-10 in some part of the world especially in South Asia[4, 5]. However, the Dissociative disorders can be better classified according to ICD-10 subcategories; though the individual subcategories needed to be defined with better clarity[4, 6]. The presence of Dissociative Identity Disorder more in America is thought be due to the more writings in newspaper, literature, novels, electronic media etc, in American society[2, 4]. However, in Europe the researchers doubted the existence of this disorder. It can be told more of a culture specific disorder[2]. In Bangladesh data regarding Dissociative Disorders is scarce though Conversion Disorder is studied much more. A clinic based study was done among the patients with Dissociative (conversion) disorders in Bangladesh. It was found that out of one hundred and twenty patients three patients were having Multiple personality disorders (according to ICD-10)[7]. Therefore it can be assumed that Dissociative Identity Disorder (Multiple Personality Disorder) is rare in Bangladesh. This case is presented here for everyone's orientation about the disease and its management.

Case history

Mr. X is a 20 year old unmarried medical student of second year from a medical college of northern part of Bangladesh. He was brought to that hospital as he felt from standing without loss of consciousness and any focal neurological deficit. The patient had light headache and he used to talk irrelevantly, as if he was a different person. However, the person later denied experiencing any such events except headache. The patient was admitted to the hospital of that medical college on last week of January 2008. His CT (Computerized Tomography) scan report was mistakenly inferred as Hemorrhagic stroke. They rushed to the neurosurgery department of Bangabandhu Sheikh Mujib Medical University (BSMMU) at the end of same month. After thorough history taking, physical examinations and reviewing the CT scan film the neurosurgeons inferred that he was not suffering from any organic brain disease. He was interviewed by psychiatrist and was referred to the psychiatry department. At the psychiatry department, he was found to adopt at least three different identities though he denied having any such events except light headache followed by transient loss of memory for an episode. However, his friends who witnessed him told that at that

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time of illness he claimed himself as the Principal of that medical college (where the person studied). He commanded others as if; he was the principal during that episode. At other times, he took either the identity of his Anatomy teacher or of a trauma victim patient with one leg. Besides, he also took a different identity which seemed to be the person himself while he was in higher secondary level. The patient when having original personality was unaware of what he told or how he behaved. However, after his admission in BSMMU, he was found to change his identities frequently if any new violent patient was admitted. He used to have different personality during any stressful situation as well.

The patient and his classmates told that two weeks prior to the illness he visited the emergency ward of the medical college hospital they studied and saw the misery of a patient who lost one leg in a train accident. The patient told that after seeing the train accident patient, he became anxious and apprehended. Since then he was persistently occupied about the thought of that accident the poor man faced. He used to see vivid dreams also. The patient felt down in the toilet though he did not loose consciousness on the day before he was admitted, in the middle of night. He had seen three different people came in front of him, one was the one legged person (train accident), another one was the patient himself (look alike) and the third person he could not recognize. He saw his look alike telling him that your days were over. Then he was terrified deeply.

The patient was born and reared up in Sylhet (a north-eastern divisional city of Bangladesh).His birth and early development was uneventful. Both his parents are school teacher. He read primary in the school where his mother used to work and higher secondary from the school where his father used to work. Mother was very strict and he was often physically punished by the mother. His friends were not allowed to his place before he completed higher secondary level. He has only one brother.

The patient didn't have any family history of mental illness. He was a very good student since early childhood and had very few friends due to his mother's tight rules. He never took any substance and had no history of anti social act. His predominant mood used to be within normal range with good attitude with seniors and juniors. After HSC (Higher Secondary Certificate) examination he tried whole heartedly to get admission in his desired medical colleges but he failed. Initially he was reluctant to study in the medical college he got admitted and spent a great deal of the time in Sylhet. As a result he was lagging behind from rest of the students. Presently he was trying to cover up the shortcomings. He was worried about that. Seeing the patient with amputated leg (train accident) in the ward made his mental condition worse.

The patient was diagnosed as a case of Dissociative Identity Disorder (Multiple

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Personality Disorder) after thorough history was taken from the patient, both parents, younger brother, medical friends (hostel mates) separately. Opinion from the consultants who attended the patient first in his own medical college (neurologist and psychiatrist) was taken over telephone.

The patient was investigated thoroughly after he was admitted in BSMMU. His Electro Encephalogram (EEG) was done and found normal. His blood count, liver function, kidney function and thyroid profile all were found normal.

The patient was referred to the psychiatry department from neurosurgery department of BSMMU. On the first day in Psychiatry ward he was found drowsy as he got benzodiazepine, his eye to eye contact was present, rapport was established and maintained, he didn't have any abnormal motor behavior or social behavior. The patients flow, rate, rhythm and tone of speech was normal, his mood was in euthymic range, and he didn't have any delusion, obsession or hallucinations. He was oriented about time place and person and was conscious. At times he appeared highly attention seeking but most of the time he was giving answers to questions. The patient didn't admit that he had any physical or psychiatric illness except light headache. On subsequent mental state examinations (when he had his own principal identity) he was anxious but he had no symptoms of mood disorders, delusions or hallucinations.

In the psychiatry department he was gradually improving. Frequency of identity changes reduced. However, he had several episode of loss of awareness and occasionally fainting soon after he had seen any new violent or disturbed patient in the ward. These episodes were very brief without any neurological symptoms or signs. He was properly counseled. Relaxation technique was shown to the patient and regularly practiced. A good one to one therapeutic alliance was established. The metabolism of psychological trauma was done by changing patient's cognition; for an example the patient used to think (before illness) no body cared for him in the medical college. Gradually he realized that his fellow friends were by his side during the time of his staying in hospital. The patient was asked whether he heard about the term multiple personality. He responded that few months before illness, he had seen a movie where the actress took different identities and was unable to recognize the identities she used to play. As the sessions were progressing patient was referred in the social skill training sessions. The patient realized how to cope with environment when things were not going right. By the time he became more close with parents and many internal conflicts were resolved. Identity diffusion began to happen (e.g., he started telling may be I behaved as if I was the anatomy batch teacher and at other time I talked as if I

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was the college principal)The patient was given suggestion; reinforcing behavior by the attendants was minimized. The patient was given discharge as his condition improved and the college friends and parents had to go back to their work stations.

Follow up

After discharge, the patient came two weeks later from the medical college he studied to BSMMU. He was accompanied by his two classmates who stayed with him during his admission in BSMMU. The patient and his classmates told that he did not have anymore identity disturbance. He was practicing relaxation technique regularly. He was also taking clonazepam at bed time for two weeks which was gradually tapered off. He was feeling much better than before. The person still had difficulties when he was anxious due to any reason. He was not comfortable when he used to study before class tests. But the patient could face situation much better than before.

Discussion

Mr. X was diagnosed as a case of Dissociative Identity Disorder according to DSM-IV TR. In DSM-IV –TR, the diagnosis requires the presence of two or more distinct personality states. The original personality is generally amnestic for and unaware of the other personalities. The median number of personalities ranges from five to ten, although DSM-IV-TR finds an average of eight personalities for men and fifteen for women[3]. The patient took at least three different identities (other than his original personality) that he could not recognize later. His thorough physical examination and investigation findings including CT scan and EEG revealed no organic lesions. He could neither recall what he told nor could he recognize that he had these symptoms. Research on the etiology of dissociation in adults has focused primarily on childhood physical and sexual abuse[8]. The patient's mother had harsh parenting style. Frequent physical abuse for silly reasons was the rule. Neither had she allowed his friends (patient's) to come to his home nor did she let the patient go outside in the evening. Recent life stressors might play the strong role in causation of the disease. In a Dutch study it was found that symptom severity was significantly correlated with recent life events not with early life trauma[9]. Mr. X was not comfortable with his anatomy batch teacher. He was teased in front of all, by the lady teacher in her class frequently. He was compelled to sit behind the girls as a form of punishment. As a result he developed low self esteem. During the time of dissociation he played the role of his batch teacher. He talked as if; she was speaking and was ordering the poor medical student to sit behind the girls. He was frightened and worried soon after he saw the one legged man (train accident) and during the time of dissociation he mentioned several times

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about the incident. He also realized that he wouldn't be able to face the situation if he would have had that accident. Moreover, he was not enjoying his first year medical life as he had to stay apart from his own family. In recent past (prior to his illness) he developed a strong feeling that no body cared for him. His class mates used to tease him due to his local (sylhetty) accent. So, all these recent events played a major role in the causation of the illness.

In the course of illness the person experienced, headache, fall from standing position. The patient did not have any neurological deficit. This complains can be separately considered as a case of Conversion Disorder according to DSM-TR[3]. However, according to ICD-10 Dissociative and Conversion disorders were grouped together. Hence it will be diagnosed as a case of Dissociative (Conversion) Disorder according to ICD-10.

Conclusion

It may be concluded that though Multiple Personality Disorder is a relatively rare disorder, reemergence of this disorder might be due to the influence of recent movies, literature, and news paper to the suggestible patients.

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