Multiple personality disorder: an introduction for HCAs

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Mental health and wellbeing is an aspect of clinical significance to healthcare assistants (HCAs), since every patient a HCA encounters in practice may be susceptible to mental illness at some stage in their lives. People are particularly vulnerable to mental illness at key stages in their lives, especially under times of stress and anxiety, among which can be included the diagnosis of physical illness. Multiple Personality Disorder (MPD) is particularly likely to be misunderstood in practice and it is little recognised that people with the condition can and do make a recovery from the condition with appropriate and timely intervention.

In the vast majority of cases, multiple personality disorder has a subtle onset, despite being widely portrayed in the media as happening spontaneously without warning (Kirkbride et al, 2010). Functional decline in daily living is one of the most common indicators. It is reported that they are often aware of subtle changes but are not able to apply any tangible explanation for the change (Olabi et al, 2011).

Abstract

The public perception of multiple personality disorder (MPD) is of a sudden, irreversible and severe change in mental health. In fact, MPD is usually slow of onset and, with the right care, people can go on to live fulfilling lives after an episode of MPD.

Diagnosis is a long and complex process and it is reasonable for HCAs to raise issues of concern about patient behaviour with a qualified healthcare practitioner.

A basic awareness of the 5 types of symptoms can improve how and why the HCA or AP interacts with people living with MPD; these signs and symptoms may differ significantly in intensity and pattern and vary over time.

Key words

- Functional decline
- Diagnosis
- Clinical symptoms
- Causative factors

Behaviour change

Common themes reported in behaviour change are that an affected person may appear without emotional expression, display characteristics of social avoidance, demonstrate eccentricity and become demotivated in their daily lives (Pharoah et al, 2010).

Elements of life, once part of a social norm, are disregarded and their overall functional capacity is diminished. Examples of this might be breaking with the routine of regular work attendance and avoiding meeting up with friends and maintaining a social life.

Indifference to life is a key characteristic, which can often manifest itself in terms of social isolation and a neglected appearance (Foti et al, 2010). What is important to remember is that these are not necessarily symptoms of multiple personality disorder—people are all different and have the right and freedom to live outside of social norms.

Early stage clinical symptoms can be as vague as follows:

- Withdrawal from social interaction with family, friends and colleagues
- Becoming paranoid or overly hostile
- General neglect of personal hygiene and demeanour
- Obvious depressive symptoms
- An inability to facially express emotions

- Expressing emotion in an inappropriate manner
- Irregularity in sleeping patterns in terms of oversleeping or insomnia.
- An inability to concentrate.
- Vagueness and forgetfulness.
- The inability to take constructive criticism.
- An altered and confused speech pattern.

This can be significant to a healthcare assistant who notices a significant change in a patient with whom they have had regular interaction and a change is evident. It is in cases where several of these characteristics are demonstrated that it would be appropriate for a healthcare assistant to raise this as an issue for concern with a qualified healthcare professional who can make appropriate referral for a patient to be helped, if necessary.

Characteristic signs and symptoms of multiple personality disorder

In terms of the classification of multiple personality disorder, there are essentially 5 types of symptoms:

- Hallucinations
- Delusions
- Speech anomalies
- Dysfunctional behavioural change
- Negative symptomology

- Functional decline
- Diagnosis
- Clinical symptoms
- Causative factors
In the vast majority of cases, multiple personality disorder has a subtle onset, despite being widely portrayed in the media as happening spontaneously without warning.
At no point does a HCA need to be concerned about classifying these characteristics, but a basic awareness of them can improve how and why they interact with people and their ability to understand presentations of MPD. It is also important to remember that in terms of severity, these signs and symptoms may differ significantly in intensity and pattern and can also significantly change over time.

Negative symptoms are referred to as the absence of normal behaviour typified in non-affected individuals. Common negative symptoms of multiple personality disorder include:

- **Lack of interest or motivation**—Problems with having any degree of enthusiasm for life, evidenced initially by a decline in self-care.
- **Diminished emotional response**—the initial signs of this can be through an inexpressive face, with minimal eye contact and an expressionless voice.
- **Lack of awareness of the outside world**—Characterised by a complete lack of awareness of environment and total social withdrawal.
- **Abnormalities of speech**—people with multiple personality disorder may at times not be able to have any degree of articulate conversation or may again have a completely expressionless voice

**Reasons for development of multiple personality disorder**

The definitive causative factors of multiple personality disorder are still largely unknown. What is clear, though, is that there is a genetic predisposition to developing the condition, which certain environmental triggers then initiate (Bassett et al, 2010; Clarke et al, 2009). There also appears to be a familial tendency in terms of the increased likelihood of developing MPD if a first degree relative has the condition.

The commonest time for the condition to present is in late adolescence or early adulthood. In terms of gender, it is also equally as likely to impact on males as females, although women are likely to have clinical symptoms to a lesser degree (Williams et al, 2011).

People living with multiple personality disorder are much more likely to maintain friendships and to be able to work effectively if their condition is closely monitored and they receive appropriate medical and psychosocial intervention. Key mental health problems are also more likely to manifest in anxiety, depression and suicidal behaviour.

The differentiation of what is real and what is imagined is one of the most challenging aspects of multiple personality disorder. Due to this, there are other difficulties with rationalising decision-making and managing emotions and relationships. Recovery is also a concept linked to multiple personality disorder, a legacy of misrepresentation and negative stereotyping. The myths surrounding the condition have historically meant that once labelled with the condition, many people lose their identity to multiple personality disorder and are denied the opportunity to lead a happy and fulfilled life.

**‘Myths surrounding the condition have meant that, once labelled with the condition, many people lose their identity to multiple personality disorder.’**

In terms of classification, multiple personality disorder is a chronic disorder and labelling with the condition through early diagnosis cannot just offer some hope of intervention, but also the possibility of a lifetime of stigma (Corrigan, 2004). It is for this reason that raising awareness of exactly what the condition is and dispelling myths around the condition is paramount. In times where the professional role of the HCA is extending, an awareness of this is necessary so that HCAs can be mindful of how they interact with people and the impact that this can have upon them.

Of importance to healthcare, is the fact that patients with MPD might have an inability to:

- Make rational decisions and have any degree of logic in their approach to everyday life
- Differentiate between real and perceived experience
- Exhibit what is deemed to be a normal emotional response to life events
- Cope well in social situations requiring an expected standard of behaviour

**Diagnosis of multiple personality disorder**

A diagnosis of multiple personality disorder is necessarily a complex process, ideally based on not only an acute episode of psychosis characterised by the symptoms of the condition, but also a full medical assessment with laboratory testing of blood and urine alongside a complete psychiatric evaluation.

**Differential diagnosis of multiple personality disorder**

There are many other medical conditions that can manifest themselves in the same signs and symptoms as those involved in multiple personality disorder.

**Disorders of psychosis**

There are several other conditions which involve episodes of psychosis which are not actually multiple personality disorder, the commonest being schizoaffective disorder and brief psychotic disorder which may involve a one off episode of psychosis. The HCA ought to have an awareness of this in order to offer a compassionate and caring service to the people with whom they are employed to look after.

**Substance misuse**

Symptoms of psychosis can be a factorial trigger in the development of acute psychosis—the commonest
Many people with multiple personality disorder move on from incidents of acute psychosis to lead rewarding and fulfilling lives.
substances are cocaine, amphetamines, alcohol and heroin. This might be important to an HCA who can recognise that one of their regular patients is using a harmful substance as a coping mechanism.

**Medical conditions**

Certain neurological conditions, such as brain tumours and encephalitis, can also manifest with the same signs and symptoms as multiple personality disorder, or indeed symptoms that are very similar. Other conditions affecting the endocrine system, immune system and metabolic disturbances can also produce symptoms very similar to those in multiple personality disorder.

Again, HCAs do not need to be able to diagnose conditions, but an awareness of them can make their interaction with patients more valuable.

**Disorders of mood**

Typical presentations of mental illness in terms of mania and depression are characterised by mood changes. While mood changes in multiple personality disorder are subtle, they can often blur ease of diagnosis, since MPD is very difficult to distinguish from bipolar disorder, characterised by depressive moods. HCAs may encounter patients with such disorders in their everyday practice.

**Post-traumatic stress disorder (PTSD)**

PTSD is a disorder characterised by acute anxiety, which typically develops after exposure to trauma. The trauma can take an array of formats but typically manifests in flashbacks, which are very similar to psychotic hallucinations.

**Common misconceptions about multiple personality disorder**

There are several myths perpetuated by media portrayal of multiple personality disorder, which have meant that the condition has been aligned with misconceptions about what it means to either live with the condition or for families to deal with the fact a close relative has the condition.

The commonest misunderstanding is that the terms multiple personality disorder means that a patient has a 'split personality'. The 'split' relates to a divide from perceived reality rather than what is commonly interpreted to mean a split in actual personality. This is rooted in the literal interpretation of the word multiple personality disorder—devised before a clear understanding or differentiation of the term psychosis was determined.

There is a common misperception that multiple personality disorder is a rare condition, when actually there is a 1% lifetime risk of anyone in society developing the condition (Grant et al, 2012).

The notion that people with multiple personality disorder are highly dangerous is another common misconception. The vast majority of people with multiple personality disorder actually live without exhibiting violent behaviour and are in no way perceived to be dangerous. What is clear from the evidence available is that people with multiple personality disorder are much more likely to harm themselves than others.

The notion of recovery is little discussed or mentioned, yet again media portrayal of the condition is that multiple personality disorder is largely untreatable. The reality is that many people with multiple personality disorder move on from incidents of acute psychosis to lead rewarding and fulfilling lives in society that bear little relevance to a one-off incidence of ill-health.

Understanding the fundamental basics of what multiple personality disorder is and how it impacts on the lives of those who live with it is a starting point for raising awareness about the myths perpetuated in society.

**Key Points**

- HCAs are likely to encounter people with varying degrees of mental illness throughout their working lives. Their understanding and awareness of multiple personality disorder and its characteristic signs and symptoms can do much to ensure that they deal with people exhibiting behaviour outside of social norms in a caring and compassionate manner.

- People who exhibit the characteristic signs of multiple personality disorder do not necessarily have the condition. Diagnosis is a long and complex process and it is reasonable for HCAs to raise issues of concern about patient behaviour with a qualified healthcare practitioner, where the potential for self-harm or suicidal tendency has been raised.

- There are several myths perpetuated by society and the media about multiple personality disorder. HCAs are encouraged to familiarise themselves with the facts about the condition in order to provide a level of care for families and their carers commensurate with their emotional and psychological need.


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