

Sybil

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Video Case Report PSY 281 – Abnormal Psychology Guilford Technical Community College For Dr. Stephen Ash Student Name(s): Kallie Roberts, Porsha, and Jarvis Date: 15, April 2013 1. Name of Video: Sybil 2. Assigned Case Character: a. Character Name: Sybil Dorsett b. Played by Actor/Actress: Sally Field 3. DSM-IV-TR Diagnoses: Axis I: Dissociative Identity Disorder (300. 14) Axis II: N/A Axis III:

Axis IV (External Stressors): Screeching sounds, like the one from the swing that triggered her flashback, and also any woman with the same hairstyle as her mother like the woman pushing the swing that caused her to flashback and lose her substitute teaching position, Sounds of piano music, the sight of any hook like objects, feeling backed into a corner like when her father told her she didn't have a problem when she knew something wasn't right. Any combative behavior toward her causes her to convert into Peggy, her younger extremely fearful self. Also if someone touched her hands she would feel extremely threatened.

And the color purple would cause alternate personalities to surface. Axis V – Current/Worst GAF: 24 Highest GAF in previous year: 75 4. Diagnostic Documentation for Axis I or II Diagnosis: Dissociative Identity Disorder (300. 14) I. Primary Diagnostic Criteria for Dissociative Identity Disorder A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self) : Sybil including her regular personality had about thirteen more.

Vanessa, Holds Sybil's musical abilities, plays the piano and helps Sybil pursue a romantic relationship with Richard. She's a young girl, possibly 12
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years old. Vicky is a 13 year old who speaks French, a very strong, sophisticated and mature personality who knows about and has insight into all the other personalities, though Sybil does not. Peggy is a 9 year old who talks like a little child. She holds Sybil's artistic abilities, and appears while crying hysterically because Sybil's fears. She is confused; like, she doesn't know that she's in New York and instead, thinks she is in the small town that Sybil grew up.

Peggy feels the greatest trauma from her mom's abuse, often feeling sad/depressed and unable to find happiness. Her biggest fears include the green kitchen, purple, Christmas, and explosions. Marcia, dresses in funeral attire and constantly has suicidal thoughts and attempts suicide. It's presumed she tried to kill Sybil in the Harlem hotel but was stopped by Vicky. She thinks the end of the world is coming, but what she really fears in the end is Sybil. Mary, is Sybil's memory of her grandmother; she speaks, walks and acts like a grandmother, and is anxious to meet Sybil's grandmother.

Nancy, kept waiting for the end of the world and was afraid of Armageddon. She's a memory of Sybil's dad's religious fanaticism. Ruthie is one of Sybil's less developed selves, a baby in fact. When Sybil thinks she hears her mom's voice, she is so terrified that she regresses into Ruthie, an alter that parallels Sybil as a helpless, regressive, pre-verbal baby. Clara, Ellen, Margie, Sybil Ann is around 5-6 years old and is supposedly very shy. Sybil also had male identities such as Mike who built the shelf in the top of Sybil's closet to hide Vickie's paintings, which she does at night.

He and Sid want to know if they can still give a baby to a girl like daddy did even though they are in Sybil's (a female's) body. He's around 9–10 years old. Sid who wants to be just like his father, loves football. He's around 7–8 years old B. At least two of these identities or personality states recurrently take control of the person's behavior: Vanessa, Holds Sybil's musical abilities, plays the piano and helps Sybil pursue a romantic relationship with Richard. Vicky has insight into all the other personalities, though Sybil does not, once Sybil lost control Vicky would step in and sometimes even attend therapy sessions with Dr.

Wilbur. Peggy, who talks like a little child, holds Sybil's artistic abilities, and appears because Sybil's fears. She is confused and doesn't even know that she's in New York. Marcia constantly has suicidal thoughts and attempts. It's presumed she tried to kill Sybil in the Harlem hotel but was stopped by Vicky. C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. Sybil told Dr. Wilbur that when she was a little girl she woke up one day and was two years older. When she was admitted to the hospital for cutting her hand she didn't know she gave Dr.

Wilbur to do neurological tests on her. She didn't even know when she got to the hospital or even how long she had been there, and when she felt smelt the fragrances Dr. Wilbur gave her she regressed into another personality, and woke up with another time lapse. D. The disturbance is not due to the direct physiological effects of a substance (e. g. , blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e. g. ,

complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

Back to Overall Video Case Report Format: 5. Etiology: According to Nevid et al. *Abnormal Psychology in a Changing World*, 8th ed. (2011, hereafter: text), Dissociative Personality Disorder (DID) formerly known as multiple personality, is a type of dissociative disorder that's characterized by "changes or disturbances in the functions of self, identity, memory, or consciousness, that make the personality whole"(p209), or "A dissociative disorder in which a person has two or more distinct, or alter, personalities"(p555). It is the emergence of two or more personalities.

In dissociative disorders, the massive use of repression "resulting in the 'splitting off' from consciousness of unacceptable impulses and painful memories"(p. 221). Those with DID express the impulses through the development of alternate personalities. In some with dissociative identity disorder their main or "host" personality does not know about the alternates, but the alternates do know about the main personality. Also the alternates sometimes won't know what other alternate personality-part has done, or even that they exist.

There can be at least two controllers of the of the person, and even the different personalities can have different ages and sexual preferences. The rate of DID is higher in women than men and females also tend to have more "splits" than males, averaging about 15 or more, than do men, who average about 8 alter personalities"(p213). The psychodynamic approach to the causes of DID, according to Nevid et al. , "Dissociative disorders include "

massive repression', resulting in the 'splitting off' from consciousness of unacceptable impulses and painful memories"(p221).

They may portray these painful memories and impulses through the development of alternate personalities. From the social-cognitive theory standpoint, the habit of mentally separating yourself from painful memories and unacceptable impulses, by "splitting off", is reinforced negatively by "relief from anxiety or removal of feelings of guilt or shame. The late social-cognitive theorist Nicholas Spanos, "believe that dissociative identity disorder is a form of role-playing acquired through observational learning and reinforcement"(p222).

They are so engulfed in the so called role-playing that they forget they're enacting a role. From a biological perspective, research is still in its early stages to determine whether brain function has anything to do with Dissociative identity disorder. But recent studies have shown "structural differences in brain areas involved in memory and emotion between patients with dissociative identity disorder and healthy controls"(p222). But the relevance of the differences haven't been determined as of yet.

Despite the massive amounts of evidence involving traumatic severe sexual and physical abuse during childhood in DID cases, those who experience severe trauma rarely develop dissociative identity disorder. In relation to the diathesis-stress model, "certain personality traits, such as proneness to fantasize, high ability to be hypnotized, and openness to altered states of consciousness, may predispose individuals to develop dissociative experiences in the face of traumatic abuse"(p222).

Not particularly that those with these types of personality traits will absolutely develop dissociative experiences, but can help trigger a dissociative phenomena when paired with a traumatic event, just as a defense mechanism. “ The most widely held view of dissociative identity disorder is that it represents a means of coping with and surviving severe, repetitive childhood abuse, generally beginning before the age of 5”(Burton ; Lane, 2001; Foote, 2005). They will split into an alter personalities as a mental defense to unbearable abuse.

When abuse of such severity and persistence continues, the alters become stabilized and hard for the child to maintain a unified personality. “ The great majority of people with Dissociative identity disorder report being physically or sexually abused as children”(Lewis et al. , 1997; Scropo et al. , 1998). In some tests 75-90% of all subjects tested were abused sexually or physically. Also according to figure 7. 1 on p224 in the Abnormal Psychology in A Changing World, social reinforcement can also lead to stabilization or even the creation of new personalities. Enactment of alter personalities is strengthened by positive reinforcement in the form of attention from therapists”(p224). According to R. P. Kluft, Temple University, “ in the 1990s there were highly polarized debates about whether multiple personality was iatrogenic, instigated and sustained by clinicians' interest in motivating patients to demonstrate the condition's phenomena, and whether the abuses alleged by patients, often recalled after years of apparent amnesia, were false, suggested by leading questions or subtle expressions of interest.

It still is unclear whether multiple personality can be created by iatrogenic factors alone”(Kluft). 6. Treatment: The most common form of therapy in

treating those with Dissociative identity disorder are psychodynamic paired with eclectic therapies, with psychodynamic being the base of therapy to get to the true root of the problems, with efforts to unify the several different personalities into one cohesive unified personality. “ However, integration of personalities is not always possible.

In these situations, the goal is to achieve a harmonious interaction among the personalities that allows more normal functioning”(Gluck). Drug therapy can be used to subdue the coexisting issues like depression or anxiety, but doesn't affect the DID. Psychotherapy is the primary treatment for dissociative disorders. This form of therapy, also known as talk therapy, counseling or psychosocial therapy, which involves talking about your disorder and related issues with a psychodynamic therapists.

Psychotherapy for dissociative disorders often involves techniques, such as hypnosis, that help you remember and work through the trauma that triggered your dissociative symptoms. The course of the psychotherapy may be long and painful, but this treatment approach is very effective in treating dissociative disorders. According to the Mayo Clinic another form of therapy is creative art therapy. This type of therapy uses the creative process to help people who might have difficulty expressing their thoughts and feelings. Creative arts can increase self-awareness, help cope with symptoms and traumatic experiences, and also produce positive changes. Creative art therapy includes art, dance and movement, drama, music and poetry. Cognitive therapy is a type of talk therapy that helps you identify unhealthy, negative behaviors and beliefs then replaces them with healthy, positive ones. It's based on the idea that your own thoughts, not other people or

situations, determine how you behave. Even if an unwanted situation has not changed, they can change the way they think and behave in a positive more unified way.

There aren't medications that specifically treat dissociative disorders; a psychiatrist can prescribe SSRI's, anti-anxiety medications or tranquilizers to help control the mental health symptoms associated with dissociative disorders. " A case study is presented illustrating how traditional long-term therapy can be defined in renewable short-term stages. At various therapeutic intervals therapy may be discontinued or deferred based on the client's definition of personal wellness. Such a conceptualization can facilitate client health while demonstrating accountability for the use of ongoing psychotherapy services" (Applegate).

The most common approach to thinking/feeling about the process of recovery from trauma or abuse is to conceptualize it as working through a series of stages. Herman summarizes several such models in a table. In the three-stage model of modern trauma therapy outlined by Herman, a phase of safety, in which the patient receives sanctuary and support and is strengthened, is followed by a phase of remembrance and mourning, in which the mind's representation of its traumatic experiences is explored, processed, and mastered and in which the losses and consequences associated with traumatization are grieved.

The mind is reintegrated, and roles and functions are resumed in a phase of reconnection. In the nine-stage treatment of multiple personality (Kluft, 1999a and Kluft, 1999b) with multiple personality (1) the psychotherapy is established and (2) preliminary interventions are made to establish safety,
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develop a therapeutic alliance that includes the alters, and enhance the patient's coping capacities. Then follows (3) history gathering and mapping to learn more about the alters, their concerns, and how the system of alters functions.

Then is it possible to begin (4) the metabolism of trauma within and across the alters. As the alters share more, work through more, communicate more effectively with one another, and achieve more mutual awareness, identification, and empathy, their conflicts are reduced, as is contemporary amnesia. They increasingly cooperate and experience some reduction of their differences and senses of separateness. This is called (5) moving toward integration/resolution. More solidified stances toward one's self and the world are reached in (6) integration/resolution.

Smooth and functional collaboration among the alters, usually including the blending of several personalities, is called a resolution. Blending all alters into a subjective sense of smooth unity is an integration. Then the patient focuses on (7) learning new coping skills, working out alternatives to dissociative functioning, and resolving other previously unaddressed concerns. Issues continue to be processed, and mastery without resort to dysfunctional dissociation is pursued in (8) solidification of gains and working through.

Finally, treatment tapers, and the patient is seen at increasingly infrequent intervals in a stage of (9) follow-up. Treatment may be challenging to patient and therapist alike. Work with traumatic material can be upsetting and destabilizing. Worse than that is the pain of tying into what patients learn to their own perceptions of their relationships, with significant others who may

appear to have been guilty of mistreatment that wasn't remembered before.. Patients should be informed about the possibility that material that emerges and may be useful for treatment may not prove to be accurate. Processing traumatic memories has been controversial because the accuracy of initially unavailable memories has been challenged"(Kluft), and the affects experienced with this process can cause upset and trigger self-destructive actions. Sometimes decompensating occurs or an inability to maintain defense mechanisms in response to stress, resulting in personality disturbance or a psychological imbalance. Some multiple personalities can't handle this kind of work. But so far " reported successful recoveries to the point of integration have involved processing traumatic memories"(Kluft).

Studies also have demonstrated that many recovered memories of DID patients have been confirmed, and some have not even been proven accurate. Opinion imply that deliberate processing of traumatic memories should not be performed unless patients have demonstrated the proper strength and stability for the work. All others should be treated supportively, addressing traumatic memories only when they are intrusive, are disruptive, and can't be put aside. Patients sometimes have periods of anting say everything said in therapy was a joke as Sybil did when confronted more about the green room, trying to banish painful memories of trauma, betrayal, and loss associated with important people in their lives to maintain relationships and a sense of safety within those valued relationships. " Tact, containment, and circumspection are required from therapist and patient alike"(Kluft). The patient should be protected from becoming overwhelmed by and lost in the traumatic situation, and treatment should be paced to

protect the patient's safety and stability. There should be no forcing or rushing. The alter system is designed to facilitate escape from pain and difficulty or, failing that, to reframe or disguise it. Alters often reenact scenarios that (in their perceptions) are tried and true methods of keeping pain at bay, even if they disrupt the patient's treatment, life, and relationships”(Kluft). Sybil displayed this when she was confronted by her father and another time when she was in therapy. In therapy, working directly with alters often may make them more prominent, but the more they're worked, empathized, and helped to communicate with other alters, their separateness is worn down, making the personality more cohesive.

The therapist should treat all of the personalities with respect, and also appreciate the immediacy, and defensive aspects of their separateness, and that they all express parts of a single personality, whose personality structure is to have multiple personalities. “ Interventions to contain alters' dysfunctional behaviors, aggressiveness toward other personalities, self-destructiveness, and irresponsible autonomy (e. g. , failing to care for children, who may be seen as belonging to another personality) may prove necessary”(Kluft).

The therapist may call on personalities to work on their particular issues in the treatment and to facilitate their cooperation with the treatment and one another. Treatment must respect the entirety of the patient's concerns. Certain DID's treatment may be put off repeatedly to address other rising concerns and other mental health issues. For example, a woman with dissociative identity disorder whose child develops cancer is not in a position to pursue trauma work. 7. Personal Application: N/A 8. References: * Nevid, J.

S. , Rathus, S. A. & Greene, B. (2011). Abnormal psychology in a changing world. (8th ed ed.). Upper Saddle River: Prentice Hall. * Gluck, Samantha; Treatment of Dissociative Identity Disorder, 2008; Hhttp://www.healthyplace.com/abuse/dissociative-identity-disorder/treatment-of-dissociative-identity-disorder-did/healthy Place, Americas Mental health Channel, web, 01/2013; 13, April 2013. * Treatment and Drugs, The Mayo Clinic; http://www.mayoclinic.com/health/dissociative-disorders/DS00574/DSECTION=treatments-and-drugs; 3, March 2011; web, 13 April 2013 * Judith L.

Herman, Trauma and Recovery, BasicBooks, 1991, p 156 * Applegate, Maureen; Multiphasic Short-term Therapy for Dissociative Identity Disorder; Journal of the American Psychiatric Nurses Association February 1997 vol. 3 no. 1 1-9 * Kluft, R. P. , Encyclopedia of Stress(2nd Edition), 2007, p783-790; * Kluft, R. P. , Current issues in dissociative identity disorder; Journal of Practical Psychiatry and Behavioral Health, 5 (1999), pp. 3-19 Sybil's "Friends" * Peggy- an aggressive nine-year old * Vicky- a sophisticated young lady * Mary- grandmother * Mike- * Sid- * Martha-