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CLINICAL CORNER: MPD PATIENTS IN THE GENERAL HOSPITAL

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Ms. Y, a patient with MPD and an extended history of abuse, was about to undergo surgery for carpal tunnel syndrome. She panicked when the attending personnel began preparing for the narcosis and were about to immobilize her; she became aggressive and began to fight with the nurses and the anesthesiologist. The latter, however, eventually succeeded in sedating her and inducing the narcosis, and the operation proceeded as planned.

As a similar operation was scheduled for the near future, Ms. Y asked her psychotherapist to explore with her the background of her panic and aggressiveness in the operating room. While under hypnosis, she realized that the scene of the medical personnel, with masks over their faces and attempting to tie her down, had served as a trigger reactivating the traumatic memory of a rape that she had experienced at age 12 involving a number of masked boys. This traumatic memory became the focus of treatment.

At Ms. Y's request, the therapist attended her both immediately before and after her next operation. He gave her suggestions that they had discussed before and that she found acceptable: While she was being immobilized and anesthetized, he asked her to look into his eyes, thus staying in contact with him, while she allowed herself to go peacefully to sleep, enabling the doctors to operate without incident (van der Hart, Boon, Friedman, & Microp, 1992).

MPD patients may suffer many hardships while being treated at a general hospital. This is because many situations, such as specific medical procedures and the operation theater itself (as in the example of Ms. Y), may act as triggers for reactivating traumatic memories. Teaching the MPD patient new coping strategies for triggers and reactivated traumatic memories is an essential part of the beginning stages of treatment. The main strategies in this respect are (a) removing or neutralizing the triggers, (b) emphasizing the "safe present" and teaching procedures to return to the present faster, and (c) creating imaginary "safe places" in which traumatized alters can withdraw when needed (van der Hart & Friedman, 1992). Within the context of an admission to a general hospital, specific attention to this topic is needed. When MPD patients in our practice are admitted to a general hospital, for example, the Free University Hospital in Amsterdam, Netherlands, one or more of the following strategies are followed:

(a) the therapist prepares the patient for expected stressful hospital situations;

(b) the therapist attends the patient during a particularly stressful situation;

(c) the therapist provides attending medical personnel (nurses, doctors) with relevant information and instructs them in helping the patient cope with specific stressful situations. In addition, close cooperation with the consultation liaison (C-L) psychiatry department, that is, with the C-L psychiatrists and C-L psychiatric nurses, should be considered. While the former may instruct the attending physicians and the ward staff, the nurses can provide detailed behavioral and psychological instructions to the nurses and, in specific cases, may themselves attend the patient in particularly difficult situations.

Strategy 1: Preparing the patient for stressful hospital situations

When a patient with MPD is to be admitted to a general hospital, it may be good practice for the therapist to discuss specific difficulties that are to be expected with the patient, in particular with alters that have knowledge of the whole internal system. Potential triggers should be identified, and adequate coping strategies, as mentioned above, should be taught. Although the removal of specific triggers is often not feasible

in the hospital, attempts to neutralize them should be made. One way of doing this is to make an audiocassette with messages designed to orient the patient properly in time and place and also mention the current helpful role of specific procedures and situations in the hospital. Such cassettes also can be extremely useful in helping the patient to return mentally to the "safe present." Teaching alters imaginary "safe places," to which they can withdraw, may be particularly helpful for coping with medical procedures and situations that are extremely stressful to them. One suggestion could be that, for the time being, no information from the other alters, the body, or the outside world can reach them. When, by whom, and in what manner they will be contacted when it is time to leave their safe place could be discussed.

An example is an MPD patient who, after a number of traumatic abortions in the context of sadistic abuse, was about to deliver her first baby in the hospital. The leading group of alters were told that an imaginary inner wall would be constructed, behind which all the alters would stay. This group decided that some of them would stay outside the wall and others would be inside. The alters made a small hole in this wall to communicate with each other. This procedure appeared to be extremely helpful to the patient during her stay in the hospital, particularly before and after the needed cesarean section.

Strategy 2: Attending the patient in stressful hospital situations

The example of Ms. Y illustrated how the therapist can be directly involved in assisting the MPD patient in a specific hospital situation. Another example concerns an MPD patient who was in a bad physical and mental state and who needed an endoscopic assessment of her esophagus and stomach. As it was almost certain (given her specific trauma history) that this would reactivate traumatic memories with which she would be unable to cope on her own, the therapist decided to stay with her during this procedure (giving soothing and supporting suggestions all the time) and to give her some support afterward.

Such interventions may, however, be too time-consuming for the psychotherapists of MPD patients to undertake often. One reason that the senior author of this article and some colleagues in a community mental health center attended patients in certain situations at the Free University

Hospital was to build an experiential basis from which to instruct the C-L psychiatric nurses in the hospital to come proficient in this kind of help for MPD patients. This has enabled these nurses also to function effectively as liaisons between the psychotherapists and the ward staff.

Strategy 3: Informing and instructing medical and nursing staff

It is extremely helpful for all parties involved when the MPD patient's therapist provides (with the patient's permission) the attending physicians including, in some cases, the anesthesiologist) and the nursing staff with relevant information and instructions. It is important to explain the differences between MPD patients and psychotic patients, for instance, in clinical rounds for nurses. Nurses should be helped to feel more at ease when communicating with these patients. In addition, the need for a consistent approach and management from all involved disciplines should be emphasized. This helps to reduce patients' anxiety. Such a consistent approach by all parties (including those on night and weekend shifts) should include good documentation of decisions. Consistency also is fostered by having one key person, who acts as a case manager. Consistent, clear, respectful, and understanding communications from the attending physicians and nurses can be very supportive and helpful to the patient. Instructions to the medical staff should always entail recommendations about how to deal with the patient in various situations. Instructions concerning procedures are crucial. These always should include concrete explanations, both before and during their execution. Sometimes, visiting the operating room with the patient some time before the operation and explaining the procedures that will occur there may be very important in reducing anxiety. To help the patient to keep a sense of being in control, it is important to actively involve the patient in the decision process regarding treatment procedures and goals. This clinical wisdom has already been advocated for patients with obsessive compulsive disorder (Bibring, 1956).

Nurses also can be instructed in how to deal with crisis situations on the ward involving triggering phenomena. For example, for one MPD patient, sunset at a certain time of year was an important temporal trigger, during which she could switch into a highly anxious or sub comatose state (even though she had been well prepared by her

therapist in the use of audiocassettes, among other things, for such occasions). The patient had agreed that the nurses were to quietly mention her name and tell her where she was and which year it was. They could inquire if she needed to listen to the cassette recorder at hand and if she did, they would put it on. As a rule, psychotherapists visiting their MPD patients in a general hospital should contact the medical team and nursing staff to have a consultation and exchange information.

As far as the involvement of the C-L psychiatry department, it has been pointed out above that many of the interventions the psychotherapist would perform with a hospitalized MPD patient can also be performed by informed psychiatrists and/or C-L psychiatric nurses. However, the C-L psychiatry department has unique experiences and expertise in guiding ward staff to deal with so-called difficult patients-for instance, when splitting phenomena occur. In our cases, we have observed in the nursing staff two communication patterns with MPD patients in need of correction and ongoing supervision: (1) over involvement and over protectiveness, and (2) negation and avoidance of the patient.

In the final analysis, the strategies discussed in this article are possible only with good collaboration with the medical team. In addition, such intensive participation of nongeneral hospital-based psychotherapists and other mental health professionals should be discussed and properly integrated with existing mental health services in the hospital, such as the C-L psychiatry or behavioral medicine departments. As far as integration of psychological management with medical treatment, it is important to clarify the roles of the different team members; i.e., the medical doctor, the nurses, other involved medical and psychological consultants, and the consulting psychotherapist (Huyse, Strain, Hengeveld, Hammer, & Zwaan, 1988).

In conclusion, as MPD patients may, because of their hardly understandable trauma history and its psychological sequelae, evoke anxiety and negative reactions in ward staff, the experiences at the Free University General Hospital point to the beneficial influence of a C-L psychiatry department involving consultants who are well informed about the dissociative disorders and knowledgeable about dealing with MPD patients. Psychiatric nurses not only can attend the patient during specific stressful situations as described above, but also can function as important role models for the nursing staff and as liaisons between nurses and the consulting psychotherapists.

References

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