An Occupational Therapy Perspective in the Treatment of Multiple Personality Disorder

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Adult persons with multiple personality disorder have survived a traumatic past. After diagnosis and the initiation of psychotherapy, they frequently face a long and arduous treatment process. During this time, intense emotions and memories are retrieved that can disrupt functional life skills in an already disjointed life. The stresses of life combine with therapeutic issues to perpetuate the dissociation that interrupts functional performance. The original traumas occurred when the child was functioning primarily at a sensorimotor level. Occupational therapy can identify sensorimotor activities that provide a focal point of control to reduce stress during the therapeutic process and to develop new life skills.

This article presents an occupational therapy perspective toward the treatment of persons with multiple personality disorder (MPD). It describes the use of daily life tasks to intervene between the present life stressors and the emerging feelings and memories of the past. As recent sources on treatment methods indicate (Braun, 1986; Cohen, Giller, & W., [sic], 1991), therapy of persons with MPD can last many years. Interventions may be needed during this time to maintain or develop functional skills to facilitate integration of past traumas with present life. People with MPD need to find ways to cope with stressful situations as an alternative to dissociation.

In this paper, I propose that sensorimotor-based activities can be used to reduce the stresses of present life so that the person with MPD can focus on conquering the effects of traumas endured in the past. The person with MPD responds to stress with dissociation. A purposeful task provides a concrete, physical bond to the present, as an alternative to dissociation. Tasks that focus on sensorimotor activity are chosen by their ability to reduce the body’s stress response. Reducing the stress response allows the patient to gradually experience and release feelings associated with severe childhood abuse triggered by present life events. This slow, unholding process promotes communication among alter personalities and provides a safe, paced release of memories and emotions.

It is not difficult to understand the innate human desire for self-directedness, or empowerment, that is sorely needed by survivors of childhood abuse. The power and control issues that surface in daily interactions involving work or personal relationships can become part of a therapy program that recognizes the importance of patient choice.

Occupational therapists are skilled at task analysis, the process of analyzing and breaking down a large task into smaller, manageable components. MPD can be viewed as a task analysis of sorts. The person with MPD has taken an overwhelmingly unmanageable situation and separated it into parts that allow survival. The separate parts create a tolerable situation that meets the short-term preeminent goal of self-preservation. Later in life, this mechanism becomes a hindrance in meeting the demands of healthy adult life. Because of this tendency to cope by internal separation, the person frequently shows varying levels of functional-dysfunctional ability when performing tasks.

Occupational therapists can use sensorimotor-based activities that help the person with MPD to develop task mastery and to control the processing of thoughts, memories, and emotions from childhood abuse. These activities can be used to restore the balance between work, self-care, and leisure, and to lead toward developing a healthy self.

The Sensorimotor Foundation for MPD

During childhood, the nervous system is primarily a sen-
sory processing system, and the child focuses on this input to receive information (Fazio, 1992). The inherent plasticity of the central nervous system permits adaptation, variability, and, ultimately, learning. To effect a permanent change in the nervous system, repetition of events becomes necessary. Ayres described this process as "a purposeful, goal-directed response to a sensory experience . . . the formation of an adaptive response helps the brain to develop and organize itself" (1979, p. 6). In the child, the sensations are modified by the nervous system at this basic level to allow processing of sensory stimulation throughout life.

The abuse that precipitates MPD begins at a young age, before the child's personality becomes defined. The abuse can be experienced via any and all sensory channels of tactile, proprioceptive-kinesthetic, visual, auditory, olfactory, and gustatory input. The abused child has no control over, or means of escape from, the sensory input experienced during these times. This input is combined with the intensely stressful emotions evoked, such as helplessness, fear, and anger (Terr, 1990). Terr described this nervous system response as follows: "The same autonomic releases for flight or flight come about—adrenaline is released, nutrients flow quickly to the muscles, and oxygen supply is augmented. But motor discharge is blocked. The child’s body—all ready for taking risks—cannot move" (1990, p. 61).

If the trauma is repetitive, as abuse often is, the events require a purposeful response that exceeds the normal neurophysiological, cognitive, and emotional abilities that exist at this emergent stage of development. The child becomes trapped in a role reversal whereby he or she becomes the caretaker, the sexual partner, or the scapegoat for an adult in an adult-centered household, rather than a child-centered one. The child must become self-reliant at an age when he or she should be dependent (Sanford, 1990).

For currently unknown reasons, the child may use dissociation as the primary defense against overwhelming physical or sexual abuse and the conflicting emotions thus generated (Braun, 1990, Skinner, 1987). The groove of dissociation becomes etched in the repertoire of responses to stressful events. With further repetition, splitting of the personality may result (Skinner, 1987). Gruenewald (1984) described the vulnerability of the budding ego structure that attempts to order sensory, affective, and cognitive experience, but also comes apart easily under conditions of stress. In My Father's House, Fraser graphically depicted the process:

> My arms stick to my sides, my legs dangle like worms as my daddy forces me back against his bed. I love my daddy. I hate my daddy. Love hate love hate. Daddy won't love me. I love my hateful hate hate. I'm afraid to strike him with my fists. I'm afraid to tell my mommy. . . . She doesn't like me because I am dirty. Dirty. Guilt, fear, guilt, fear, dirty. Dirty. Fear. Fear. Fear. Fear. Fear. Fear. One day I can stand it no longer. I created a secret accomplice for my daddy by splitting my personality in two. (1988, p. 1415)

The development of multiple personality disorder becomes an adaptive response to the trauma of abuse.

A person becomes traumatized during abuse by feeling utterly helpless. The repeated abuses flee conscious awareness (Terr, 1990). Braun (1990) proposed that the emotions and memories stored during this neuropyschophysiologic state of stress become chained together by state-dependent learning. In this process, the sensory, affective, and cognitive information that is encoded into the nervous system in a particular state is best retrieved when the person is in the same or similar state. When a stressful state is evoked, by conflicts relating to authority, or even by benign events, the memories and feelings associated with the original traumas rise closer to the surface of conscious awareness. The person with MPD experiences difficulty coping with current events that reproduce feelings reminiscent of abuse.

The current life events are seen from the perspective of feelings from the past, one of which is anger. A stressful event may produce a feeling of anger that cannot be presently acknowledged because it connects with the overwhelming anger experienced during past trauma. In the past, the child was not allowed to take effective action to express anger during the abuse. In the present, the adult feels the same sense of internal chaos and disruption that the child experienced years before. The repetition of stress, coupled with the reinforcement of dissociation to avoid conscious recognition of the traumas, is a pattern that continues throughout the life of the person with MPD. What was once an adaptive response to a specific set of circumstances loses its usefulness by becoming a rigid response that conflicts with the flexibility required to function in a healthy adult life.

**Occupational Therapy Interventions for MPD Stress Reduction**

The key to functioning during the healing process of MPD is in performing daily life tasks to reduce stress and provide empowerment and task mastery. Occupational therapy can assist the adult with MPD in identifying specific tasks that inhibit stress in the nervous system, which will affect the MPD system. Activities produce stress reduction in a variety of people. But because the person with MPD uses dissociation as the primary response to stress, he or she needs to make a planned effort to change behaviors and find alternate ways of stress reduction.

Inhibitory input, as described by Rood (1956), includes rhythm, light, repetitious sounds, or cutaneous stimuli, as well as warmth of body temperature. More recent sources (Ayres, 1972, 1979) specifically identified tactile, vestibular, and proprioceptive stimuli and activities that produce inhibition in the nervous system. One might wonder whether the effects of this input are different in the nervous system of a person with MPD, but as Gruenewald stated, "it is one nervous system that processes all exteroceptive and interoceptive information."
boundaries, and produce developmental mastery. Caring for plants or creating a "pain-getting-better" book, expressive therapies (Frye, 1992) of such expressions may be merely sore arms and a flat anger is difficult to consciously acknowledge. The person may avoid doing openly aggressive tasks. Also, the results of such expressions may be merely sore arms and a flat anger. For example, a patient chooses to remodel and furnish a dollhouse for her daughter. This project can provide a calming space in which the person with MPD can slowly regain control over feelings and learn to process current events in relation to past traumatic events. Thus, constructive solutions to currently stressful events can be developed.

Rood (1954) suggested that certain jobs should be performed during times of stress to provide a constructive outlet for emotions that evoke a sympathetic nervous system response. Treatment can focus on activity-based tasks that access their metaphorical meanings, such as caring for plants or creating a "pain-getting-better" book, methods that have been successful with children (Fazio, 1992). Physical activity (Richert & Bergland, 1992) and expressive therapies (Frye, 1990, 1991) use sensorimotor processes that release tensions, provide structure and boundaries, and produce developmental mastery.

One might envision that the person with MPD who feels angry should perform an activity to release anger, such as hitting pillows. But a dilemma of MPD is that the anger is difficult to consciously acknowledge. The person may avoid doing openly aggressive tasks. Also, the results of such expressions may be merely sore arms and a flat pillow. A productive activity that incorporates what is known as constructive destruction into the task may be more effective as an indirect way of releasing the affect of anger. For example, a patient chooses to remodel and furnish a dollhouse for her daughter. This project can provide a healing opportunity for child alter personalities to play, creative alter personalities to be expressive, and angry alter personalities to be destructive. This activity can be part of daily or weekly routines. By identifying and engaging in stress-reducing activities, the person can gain a sense of control and mastery over the external environment and the internal emotions, and some of the pressure can be released from the intense feelings that have been walled off for so long. Repetition of this process produces a new groove of stress reduction for future events to follow.

Empowerment

The physical-sexual-emotional aspects of abuse are merely the manifestations of an abuse of larger scope and consequence, that of powerlessness and loss of personal integrity. The child's body becomes the vehicle through which this destruction is wrought. The power to consent or withhold consent over concrete bodily dimensions vanishes (Fortune, 1983). The feelings of utter helplessness experienced by the child during the period of abuse are pocketed off in MPD into other personalities. Although they are not consciously recognized, these feelings remain and are transformed into the person who consciously feels responsible for the abuse. This feeling of responsibility is generated to avoid the abysmal realization of helplessness and complete loss of control (Torem, 1990). The memories may become stored in the body (Bass & Davis, 1988; Richert & Bergland, 1992). Self-destructive feelings and behaviors may lead to revictimization (Tower, 1988) and learned helplessness (Sanford, 1990).

Remembering, sharing, and processing the trauma begins the process of changing helplessness into empowerment. As stated by a person with MPD, growth occurs by making a transition from "the innocence we maintain by remaining helpless" to take responsibility to heal, grow, and mature (Cohen et al., 1991, p. 159). Empowerment allows the person to gain, or regain, a sense of control and accomplishment (Gage, 1992). The adult survivor has an opportunity to become empowered through effective psychotherapeutic relationships, using an adult cognitive perspective, with a chosen support system of family and friends. Occupational therapy can contribute to this empowerment by providing the opportunity for a therapeutic relationship and by identifying opportunities for the person with MPD to regain control.

Task Mastery

Task mastery can provide a concrete external product that results in empowerment through increased internal cooperation and communication among alter personalities. In the example of redecorating and furnishing the dollhouse, the various parts of the person with MPD can see the progress being made toward completion of this task. Internal communication increases when external sensory input is processed by a number of alter personalities. The results of the painting, wallpapering, and furnishing being done during each session provide physical evidence of internal cooperation. It is the process, not the product itself, that needs to be emphasized. The style and quality of the workmanship may vary according to which alter personality has the most influence over the body at the time of task performance.

Empowerment through daily self-care activities can provide boundaries, structure, and soothing rituals to promote a sense of personal control. Leisure activities
may permit greater self-expression among alter personalities. Creative hobbies may open the way for more playful tasks to promote healing in alter personalities whose function it is to harbor anger or sorrow or to experience abuse. Recovery from MPD is a constant, ongoing process. Therapists and friends may not always be available for support. The initiation of self-empowerment is an important concept. By identifying tasks whose mastery will contribute to self-empowerment, the occupational therapist can further help the person with MPD to regain control.

Richert and Bergland (1992) and Fike (1990) stated that persons with MPD exhibit varying developmental levels of functioning among the alter personalities. The tasks performed at any particular time will reflect the functional level of the person at that time. Activities that do not place high-level demands and that provide structure in their simplicity may be needed, especially during times of stress. There may be times when the person will need daily structured plans and goals. These goals may need to be defined hour by hour or to be stated as general goals for the day. For example, such a plan could read, “Morning—wash and dry clothes, afternoon—cook supper, evening—work on dollhouse, bedtime—read to children.” In the past, the abuse was perpetuated via sensory input, creating the overwhelming emotions that the person desperately avoids feeling. In the present, when stressful feelings threaten to overflow, the person with MPD can be helped by performing controlled, chosen sensory-based tasks to change the feeling of helplessness into the feeling of personal power. The range of activities can be increased in complexity as tolerated. Artwork and journal writing can be used to identify problems and develop plans.

Some considerations can be defined to assist the occupational therapist and patient to determine therapeutic tasks. The most important aspect to recognize is the person’s response to the task. The task must show therapeutic value rather than replicating abusive conditions. The task should not harm the patient, therapist, or any other person. The task must be purposeful and create a product or result that is meaningful and desired by the patient. The task should encourage age-appropriate functioning rather than regressive behavior.

It is imperative that the person with MPD achieve a feeling of success and task mastery. Not all tasks or activities will be successful for any one patient, according to the unique associations that the patient has to sensory components of the task. An activity that is soothing to one patient may trigger painful memories prematurely in another patient. Trust between therapist and patient is essential as well as the realization that therapy is a slow process.

Occupational therapy can assist the adult with MPD to integrate mind, body, and spirit through purposeful activity. Frye (1990) identified occupational therapy’s unique contribution as providing the action that makes insight functional. Persons with MPD must gradually trust in this knowledge to change old, dysfunctional behavior patterns. The insight should come from the patient, from the inside out. The therapist may guide and assist, but the cognitive and emotional connections are made by the person with MPD. Skinner (1990) described doing as a purposeful, rather than random, action that facilitates the patient’s comfort level and can increase a sense of control. In describing children’s perceptions of control, Coster and Jaffe (1991) noted that young children cannot reliably distinguish between random and nonrandom occurrences, thus they overestimate the degree to which they control events. In childhood abuse, the child takes on the responsibility for the abuse, and even as an adult he or she may recreate victimizing situations. Purposeful activities provided routinely, such as baking cookies, can create a focus of external organization to facilitate internal stability and organization. Furthermore, by direction of conscious attention to the task, organization of the MPD system occurs below the conscious level. This process permits greater communication and gradual changes within the MPD system toward functioning at a more cooperative level.

Fidler and Fidler (1963) identified the connection between the intensity of the actions and the emotions processed during the activity. Large, vigorous motions required by an activity allow the release of more hostile and aggressive emotions than do small, refined motions. Initially, a patient may not be able to deal with large motions while feeling angry, for fear of losing control. In the example of the dollhouse, the person may have difficulty performing an aggressive action such as pounding nails. The occupational therapist can suggest that the pieces of wood be glued together instead. Perhaps later the person will feel more comfortable using nails. The adaptations and choices offered to the patient in this process counteract the subserviency of past abuses. The desired result is achieved while the person’s needs are recognized.

To provide specific examples, some activities will be presented to highlight this concept of daily purposeful tasks and soothing rituals. The examples are not intended to be a cookbook list of tasks. Rather, they are meant to provide a basic approach toward the identification of specific tasks appropriate to the individual patient with MPD.

The task may be repetitive and routine. It may give a feeling of security when functioning is low. Doing laundry, cooking, gardening, walking, cleaning house, rocking in a rocking chair, and bicycling are some examples. At times, an activity with boundaries and structure may be needed to contain fear, anger, and out-of-control feelings. These could include crocheting, doing cross-stitch, quilting, writing, drawing, and stenciling. Other tasks may involve gross motor movements that require increased physical resistance to overcome the forces of the objects. Examples are pounding wood or metal, sawing or sanding...
wood, scrubbing walls and floors, exercising, kneading dough or clay, and refinishing furniture. The activity may use constructive destruction, as do woodworking, sewing, gardening, and cooking. It may decrease the stress response and give soothing sensory input, such as the warmth and pressure of blankets, a scented bath, music, rhythmic movement, or foods. Self-nurturing tasks can be explored to identify favorite foods, relaxation techniques, or exercises that provide a feeling of well-being. Routines can be developed to provide soothing rituals. Even household tasks can be examined to identify those most suitable to perform when functioning is low, such as washing or folding laundry, and those that require a higher functional level, such as planning a party. Journal writing and expressive drawing help to identify feelings, process information, and make plans.

Summary

Occupational therapy can help the person with MPD to identify sensorimotor-based activities to provide continuity in a life that frequently feels disconnected. These activities can be used to develop a stable base to build an internal bridge that allows mobility and communication between the thoughts, feelings, and actions experienced by the entire system of multiple personalities. They can be used to keep intensely painful feelings and memories from prematurely erupting and disrupting the functional abilities of the patient. They can be used as a safety valve to permit processing and slow release of these feelings to a more manageable level.

Records of successful treatment for MPD need to be developed. Narrative reports and case studies need to be written on the effectiveness of occupational therapy in the treatment of MPD. These reports could develop into qualitative research to define concepts, document results, and refine techniques. This knowledge is needed to expand the comprehensive base of knowledge used by all professions required in the treatment of MPD. ▲

References


