Art and Multiple Personality Disorder: An Expressive Framework for Occupational Therapy

Becky Frye

Key Words: art • multiple-personality disorders • occupational therapy in psychiatry

Patients with multiple personality and dissociative disorders have learned to create an alternate identity system, originally designed to protect them from experiencing the pain of inescapable, unrelieved trauma and abuse. The resulting amnesia and identity confusion cause significant dysfunction in daily living. Issues of trust and control are paramount, and occupational therapists are challenged with the task of engaging these patients in meaningful activity. Although these patients often avoid structured groups, they have generally been responsive to expressive art opportunities as an initial activity. This paper outlines an expressive framework by which occupational therapists can therapeutically manage the artwork behaviors of the patient with dissociative or multiple personality disorder. The material presented is based on clinical observation of more than a dozen patients with multiple personality disorder in various stages of recovery and of many persons with dissociative trauma who may have multiple personality disorder. These observations took place within an acute care, inpatient occupational therapy setting. Guidelines for the creation of a positive working alliance and therapeutic climate for self-expression are outlined, and a progressive model for the viewing of patients' art products is described.

Becky Frye, OTR/L, is Senior Occupational Therapist at Akron General Medical Center, 400 Wabash Avenue, Akron, Ohio 44307.

This article was accepted for publication June 27, 1990.

The American Journal of Occupational Therapy
thereby diffusing the pain and delegating the burden of memory. The separation from and amnesia about various experiences originally helped the child survive ongoing trauma and abuse. This once functional coping mechanism, however, causes at least as many problems in adult living as it originally avoided in the past.

Treatment approaches must address dividedness of wants, needs, feelings, opinions, and goals in the patient without the benefit of an ongoing observing ego or continuous memory (Kluft, 1985). The creative division that was once lifesaving often works against current unity of purpose and motivation in therapy. The patient's internal system can easily misinterpret therapy as a direct threat to a dissociated state's existence or job. Some studies indicate that 97% of patients with multiple personality disorder have been subjected to child abuse (Kluft, 1987). The repressed abusive material is highly resistive to exposure, largely due to the patient's internalized rule to remain silent under the threat of further punishment. These patients have been warned by their abusers not to talk about their abuse. Consequently, the treatment of these patients is continually confounded by the injunction to secrecy and their inability to tell, which limits the scope of traditional verbal therapies. Dissociation in response to crisis makes insight elusive. Time loss, the delusion of separateness, and conflicted internal messages produce significant disruptions in daily living.

Most experts agree that the establishment of trust and a solid therapeutic alliance are vital to every other aspect of treatment for these patients (Braun, 1987; Caul, 1983; Kluft, 1987, Wilbur, 1984). All approaches to these challenging phenomena "sink or swim on the strength of the therapeutic alliance established with the person" (Kluft, 1985, p. 5). The literature acknowledges the value of the use of adjunctive tools with this population, especially the expressive therapies (Braun, 1987; Caul, 1983; Coons, 1986; Kluft, 1985). Eighty-two percent of patients with multiple personality disorder show high creativity as well as fluctuations among alter personalities in art styles, poetry, music, and handwriting (Shutlz, Braun, & Kluft, 1985). The arts apparently provide an avenue of self-disclosure that appeals to the creative nature of these patients. A possible explanation for the effectiveness of the expressive therapies in breaking through patients' persistent denial and mistrust is that at some internal level, these patients respond positively to those persons offering safe release from the pain they cannot voice. Unconditional acceptance of their artwork helps patients believe that they too are acceptable, regardless of what has happened to them in the past. Their artwork can serve as a therapeutic bridge to rapport and confidence.

**Occupational Therapy Rationale**

In 1972, the American Occupational Therapy Association (AOTA) defined occupational therapy as "the art and science of directing man's participation in selected tasks . . . to promote and maintain health" (AOTA, Council on Standards, 1972, p. 204). In 1981, AOTA redefined occupational therapy as "the use of purposeful activity with individuals who are limited . . . in order to maximize independence, prevent disability and maintain health" (AOTA, 1981, p. 798), deleting the descriptive phrase "art and science" in response to the trend toward scientific research and accountability. Peloquin (1989), however, made a relevant observation in her refreshing article about the art of providing occupation as therapy. She asserted that it is precisely because of this trend that the art of practice must be valued and nurtured. "The art of occupational therapy is the soul of its practice. . . . Without art, occupational therapy would become the application of scientific knowledge in a sterile vacuum" (Peloquin, 1989, pp. 219-220). She also said that "although practitioners reduce the human organism into subsystems in order to understand the patient more clearly, the art of practice reintegrates those subsystems to see a whole person" (Peloquin, 1989, p. 220).

In the patient with multiple personality disorder, the dissociated state can be likened to a kind of subsystem within the patient. Each subsystem or state can be separately examined in a scientific manner for information about its form and function, but it is the art of occupational therapy that helps these patients see the whole picture and learn to reintegrate their subsystems into a unified, functional whole. Expressive modalities are an area in which the art of occupational therapy, rather than the science, is most important; it provides the patient with intrinsic problem-solving tools that contribute to the arduous process of recovery. Regardless of the treatment framework, occupational therapy's specialty lies in the balanced application of the art and science of occupation as a therapeutic tool.

Occupational therapy's strength has always been that it values and reinforces the inherent necessity for human beings to act on their own behalf. The profession's unique contribution is to provide the action that makes insight functional. Without the active application of knowledge, people tend to return to old patterns and repeat the past; this behavior is particularly problematic with patients with multiple personality disorder. All of the health care professions, including occupational therapy, are currently struggling to discover verifiable, effective methods to use with this population. Without hard data and research, therapists must frequently act on instinct and sheer com-
passion in response to the overwhelming needs of these patients. Still, the literature is beginning to reflect occupational therapists’ application of their expertise to the needs of patients with multiple personality disorder (Christensen, 1987; Dawson, 1985; Santschi & Fisher, 1989; Schlatter & Robertson, 1988; Skinner, 1987). Occupational therapy has many frameworks from which to formulate treatment strategies. The endorsement of one treatment method over another is speculative at present, but the following frames of reference have lent direction to the development of the expressive treatment approach presented in this paper.

Frames of Reference

Because of its holistic and activity-oriented approach, occupational therapy has much to offer in the treatment of patients with multiple personality disorder. Purposeful activity has been examined under many frames of reference for both its intrinsic and therapeutic value. This paper draws support for the use of expressive modalities with patients with multiple personality disorder largely from the object-relations framework, which grew from early psychoanalytic approaches in occupational therapy developed by Azima in 1959, Fidler and Fidler in 1963, and later expanded by Mosey in 1970 (Bruce & Borg, 1987).

Object-Relations Framework

According to the current object-relations view, a person is a “dynamic energy system composed of parts known to himself (conscious) and parts of which he is unaware” (Bruce & Borg, 1987, p. 56). The constructs of the id (which knows what it wants but not how to get it), the ego (which organizes and tests reality and removes obstacles to satisfaction), and the superego (which judges right and wrong, also known as the conscience) provide the psychic structure of personality. In the object-relations therapy process, the occupational therapist traditionally used activities in which the patient could project aspects of his unconscious into the visible therapeutic milieu. “Patients were encouraged to use such unstructured media as paints, clay, and collage, since these tended to facilitate symbol production, especially personal, unconscious symbols, which could then be seen and integrated into consciousness” (Bruce & Borg, 1987, p. 47).

The object-relations theory depends on the therapist’s belief in the integrity of subjective experience and a focus on bringing unconscious material to awareness. Much of the experience of the patient with multiple personality disorder is outside direct awareness and involves isolated pockets of intense polarized memory and emotion. Trust is a primary issue. The natural needs and drives of the original child have been denied. The moderating function of the observing ego has been disrupted by amnesic barriers, thereby giving drives, fantasies, and wishes free reign. One of the criticisms of this psychoanalytic view is that it is difficult to observe and thus verify the workings of the unconscious or to test subjective reality.

Transactional Analysis

This is a related framework that patients can apply more directly to observable ego state phenomena (i.e., parent-adult-child). This model can be useful in the organization and grouping of alter personalities by function and behavior. The child ego state responds naturally to the inherent qualities of expressive media. In transactional analysis terms, art beckons the child, overrides the parent, and feeds the hungry adult with healing images and truths (Frye, 1989).

It is interesting to note that both Freudian theory and transactional analysis correspond to recent studies on the lateralization of brain function, in that the Child ego state (i.e., id) contains many of the right brain attributes of creativity, intuition, and visualization, and the Adult ego state (i.e., ego) closely resembles the logical, linear, computerlike left brain. To a child who is senselessly, continually hurt and condemned to silence, the logical left brain, with its cause-and-effect and time-and-space constructs, offers little protection or escape. The right brain, however, lives in a state of timelessness and does not see events as occurring logically. It is through the right brain, with its ability to intuit, visualize, and deal with affect, that the patient with multiple personality disorder is able to survive and find internal strength. Thus, when logic and reason fail, tapping of the right-brain skills in these patients can help them to see the whole picture.

Setting Up a Therapeutic Alliance

For use of the interventions that would naturally develop from an object-relations model, the transactional analysis concepts of permission, protection, and potency (Woolams & Brown, 1978) set the stage for engagement of the patient with multiple personality disorder in the risky exploration of unconscious material. First, these patients need explicit permission to share their experience. They have always lived in secrecy. They know they sound crazy. They have been called liars all their lives. They are not sure who knows what, how much is safe to reveal, or who believes in their illness. They have been misdiagnosed, mistreated, and misunderstood. Studies show that for patients with multiple personality disorder, an average of 6.8 years elapses between the time they are first
assessed and the time they receive an accurate diagnosis (Gilbertson & Torem, 1987; Putnam, Guroff, Silberman, Barbán, & Post, 1986). Putnam et al. stated that during that time, these patients will have received an average of 3.6 erroneous diagnoses and that approximately 94% of them will try to hide and deny or dissipate their condition.

Second, protection is essential to ensure that the patients know they will not be allowed to hurt themselves or anyone or anything, that they will not be hurt for what they do or say, that measures will be taken to ensure their safety, and that feelings differ from actions. The strength of these patients' concentrated pain, fear, and rage can be frightening and overwhelming. They need to be assured that they can both release the hurt and anger and stay in control and that the therapist will help them do this.

Finally, potency refers to the strength of the therapist and his or her ability to witness and deal with whatever material emerges. A therapist treating patients with multiple personality disorder once remarked, “If they endured and lived through this, I can certainly hear it” (Comstock, 1986). Because of the enormous potential for transference and countertransference issues connected with the intensity of these patients' pain and the character pathology frequently encountered, supervision is essential for the therapist working with the patient with multiple personality disorder. Supervision can be informal, for example, through trusted colleagues, the primary therapist or psychiatrist, or a support or study group. Alternatively, it can be a formally contracted supervisory relationship or group designed for that specific purpose. Regardless, the patients need to know that they will not have to take care of the therapist as well as of themselves.

Once these three conditions for treatment have been clearly established, a therapeutic atmosphere for the use of expressive art can be created.

Creating an Expressive Environment

Patients with multiple personality disorder respond to art as a springboard activity for several reasons. Art provides them with a way to tell their story. The powerful injunction to secrecy, which is typical in patients who have been abused, previously inhibited integrated awareness. Patients with multiple personality disorder have trapped secrets that seek release, and the alter personalities quite naturally and cleverly sense a way to tell through art without actually disobeying the rules. Artwork is controllable. It can be large or small, messy or neat, clear or disguised, shared or not. This quality often appeals to the patient who originally had no power. Artwork is changeable. Patients cannot alter the reality of their past, but they can change the way they look at that past by releasing their pent-up emotions through imagination and fantasy. Artwork also provides a way to structure time. It is evidence of how time has been spent, which is important to a patient who continually loses time. Artwork provides the patient with a safe way to show the strong regressive and aggressive feelings so frequently disallowed in overcontrolled children. It is a pictorial history showing a connected network of inner experiences. The continuity and consistency of remembered images among alter personalities separate fact from fantasy for the patient, thus making it difficult to deny the reality of that which is so tangible and visible. As painful as that reality may have been, patients need the integrating sense of wholeness and continuity that is their unique life story. It is therefore not surprising that these patients are attracted to art.

In an acute inpatient setting, expressive art can be used to enhance journal work. The patients can be given various art materials to use in their rooms and asked to share their artwork on a consistent basis. This encourages alter personalities to express themselves in their own way, as they are ready, and gives staff members more time to pursue other activities. Some alter personalities are shy or suspicious and require privacy as they initially reveal themselves. The therapist may wish to reinforce to the patient that acting out is unacceptable and will not be tolerated and that strong feelings must be communicated in words, writing, drawing, or other art forms. If a stimulating variety of art materials seems to escalate acting out behaviors, smaller paper and a single pencil can be substituted to reduce or confine stimulation and provide a controlled outlet. Because various members of the treatment team encounter the patient's artwork, it becomes a valuable communication tool and can be accepted without reliance on interpretive tools.

In addition to ongoing artwork, one-to-one sessions in occupational therapy can provide patients with specific structure and therapists with the opportunity to work directly with dissociated material and advance treatment goals. Patients with multiple personality disorder have an uncanny sense of timing and seem to know what materials are right, what limits are needed, and how much can be digested in a given session. They like being trusted. They like the feeling of directing themselves. They like the mystery of their images and the freedom to give themselves away as they choose, within clear and safe boundaries. Although the conditions of permission, protection, and potency have already been established, contracts for safety of person and property need to be clarified continually.

The therapist's initial task is to reduce inhibition so that the patients may risk giving form to their fears and feelings. The lateralization theories of brain
function can provide direction at this point. Theoretically, the left brain will reject the challenge of tackling the unknown, because the unknown does not make sense. The right brain, unconcerned with logical sequencing, is relationally and spatially oriented and will frequently wish to explore. Unfamiliar, unpredictable, expressive exercises invite right-brain spontaneity and tend to allow for alternative avenues of creative communication. This function of the right brain can provide parts of a puzzle that can later be assembled with left-brain reasoning (Edwards, 1979).

For a patient whose condition is undiagnosed but who is suspected to have dissociative or multiple personality disorder, a nondirective, casual manner will minimize a defended, reactive response to the therapeutic use of art if the patient's condition has already been diagnosed as dissociative or multiple personality disorder, a more directive, straightforward approach can be used to create a working alliance with art activity.

The following guidelines can provide structure to those who use media with patients with multiple personality disorder (Frye & Gannon, 1990):

1. Ask patients to sign, date, and keep all work, regardless of whether they remember doing it.
2. Encourage the language of ownership to reduce further splitting, that is, the use of such phrases as "the part of me that drew this" rather than "I did not do this."
3. Ask to see whatever the patient has done. Although the content may be disturbing and unsettling, the patient will seek validation and will notice if no one acknowledges his or her work.
4. Accept all work nonjudgmentally. Alter personalities, especially self-punishing, angry, or cruel parts, need acceptance from staff members and will test such acceptance.
5. Ask patients to talk about their work. Open-ended questions, such as those beginning with the words who, what, where, when, and how, are helpful.
6. Own your own reflections and observations, when made. Recognize that interpretations may say more about the therapist than about the patient.
7. Allow patients to decide what to do with their art; they may want to keep it, hide it, display it, or give it to the therapist for safekeeping. A plan may occasionally be made to destroy a project for therapeutic reasons.
8. Encourage patients to continue to do art along with their journal work.
9. Suggest ideas as homework if the patient seems lost or blocked.
10. Most importantly, give patients praise and reassurance for their courage and bravery, for taking a risk, and for trusting you with their art.

A Progressive Model for Viewing Patients' Art

I have learned from my clinical observations that patients’ visualization and depiction of their lives change as they progress in therapy. I have outlined these changes as separate phases and described general trends seen during treatment over time. This model is meant to provide visual clarity and direction for both the therapist and the patient in the often chaotic journey toward recovery.

The artwork of patients with multiple personality disorder can be grouped into four phases: denial, awareness, resolution, and emergence.

Denial

Denial, the initial phase, serves to defend the host from the terror and utter helplessness that he or she experienced as a child. A system of dealing with the past has already been created and is staunchly, but unconsciously, guarded against intrusion. Intrapsychic processes are compartmentalized, but all have a single goal: to protect the original child.

To use transactional analysis terminology, the denial phase usually evokes rigid, resistive parent ego states or passive, compliant child ego states. The adult ego states can usually understand the logic of trying art as a practical tool of self-expression. Dissociation may be subtle at this point, and trust may be an obstacle.

Patients in the denial stage are just learning about their condition and vacillate between disbelief and a need to know. They may display an attitude of casual indifference with a willingness to peek, experiment, and explore, but they do so from a vantage point of control. They are ambivalent. As bad as things seem now, they may get worse. And, in fact, things do seem to get worse as secrets and memories arise and the patient begins to sense what lies within. Attempts with art in this phase tend to be structured and carefully controlled, as patients acquaint themselves with the media. Patients instinctively resist or refuse to work with large or messy projects. They often challenge the therapist to explain what their work means. A frequent response of patients to their art is, "This doesn't tell me anything." Borders are often neatly kept, pictures may have no meaning to the patient, and the patient may say, "I don't know what to draw or make." The patient's participation in nonthreatening, loosening-up exercises such as scribbling, using the
nondominant hand, drawing with the eyes closed, or drawing upside down is helpful in reducing resistance. The therapist can observe changes in handedness, posture, pressure, mood, voice, eye movement, and reaction to work produced, all of which may aid in diagnosis. Early art can also serve as a foreshadowing of work to come. Themes observed include segmented geometric forms, clowns, garbage disposal, walls, barriers, and overt denial (see Figures 1 and 2).

**Figure 1.** Denial phase: Self-portrait drawn by a patient prior to her uncovering of extensive early abuse. The patient literally could not face her past.

**Figure 2.** Denial phase: Spontaneously drawn first picture by a patient admitted with an eating disorder whose condition of multiple personality disorder had not yet been diagnosed. The patient did not know why she drew this picture.

**Awareness**

In this next phase, the reasons for the fierce denial mechanisms begin to surface as conscious knowledge. Sensing the permission, protection, and potency of the therapeutic alliance, the child ego states tend to emerge and draw their memories and perceptions. This activity usually triggers strong parental injunctions against telling, at which time the therapist can teach the literal-minded parent ego states that telling in pictures is not the same as telling in words. The awareness pictures puncture denial and provide historical continuity, as the adult ego states begin to face the truth.

In this phase, patients generally know and intellectually accept their diagnosis and struggle with bits and pieces of memories. The implication of having an internal group of strangers within who seem to function independently begins to have an effect. Nonverbal media can, at this point, allow the patient to reveal and share painful memories and trauma. Art offers a way to speak the unspeakable. Persons who are abused are told not to tell, but not necessarily not to draw. Artwork at this phase often depicts straightforward, clear, childlike renditions of abuse (see Figures 3, 4, and 5). As repressed material is freed, the patient recovers memories in a safe, contained, controlled manner and traps them in a picture that can then be folded, turned over, turned in, hidden, destroyed, or talked about from a comfortable distance. Much like a}

**Figure 3.** Awareness phase: The host vaguely sensed something about hands. Later, the patient remembered extensive satanic victimization.
Journal, artwork becomes a communication device that lets the dissociated parts and the host know about each other’s presence, pain, and reason for being.

Resolution

In the resolution phase, long-repressed feelings have been mobilized and begin to challenge each other for position as their roles change. Artwork frequently reflects relational themes and intrapsychic conflict. In transactional analysis terms, this phase resembles a free-for-all of critical and nurturing parent ego states, rebellious and compliant child ego states, and referreeing adult ego states who serve to oversee and guide the resolution of the impossible binds of the past.

As the patient becomes familiar with the internal cast of players, he or she can act out fantasies, transfer homicidal and suicidal urges onto paper, and safely redirect energy. Patients begin to learn about early negative messages and double binds, to change their perspective, and to question their usually erroneous conclusions, such as “It was my fault,” “I was bad,” “I was not supposed to be born,” or “I cannot bear this and live.” Collective bargaining, internal alliances, and dialogues are often depicted in artwork. Conflicting and cooperative art efforts among alter personalities are common (see Figures 6, 7, 8, and 9). Art during this phase serves as a powerful tool for allowing the patient to express anger and aggression in a safe, acceptable manner.

Emergence

The last phase of recovery, emergence, refers to the reconnecting of the internal psychic processes through conscious control and insight. The adult ego state has successfully learned to turn off harmful or critical parent messages, to program self-nurturing parent behavior, and to respond to and arrange to meet the needs of the free child. Creativity is unbound, thus allowing the assembled self to emerge, scarred but whole.

Redefinition of the self occurs as the patient begins to embrace the total sum of his or her former parts. As issues are successfully resolved and restoration work takes place, the patient’s collective identity takes on healthy boundaries that encompass all that
make up the core person. Patients become secure in the knowledge that their condition is curable, that they are complete, and that they can live fully functional lives. They know they can cope with and control whatever emerges. New coping skills have been learned and reinforced, so that dissociation is no longer the defense of choice. Early trauma and terror are transformed into strength and beauty (see Figures 10 and 11). Emerging self-acceptance and hope can find expression in the free, uninhibited use of art media. Art will reflect this freedom and can continue to be an effective and meaningful outlet for the recovering patient with multiple personality disorder.

Artwork produced over the course of treatment may not always follow in the same order, and the phases may overlap. Regression to earlier expressive stages is common at times of emotional overload. Patients may become stuck in denial or fixated in recovering memories and resistive to the resolution process.

Figure 7. Resolution phase: Patient’s depiction of how her dissociated anger felt to her. Picture shows satanically abusive grandfather, who had killed her pet hamster to ensure the patient’s silence.

Figure 8. Resolution phase: Patient explained that “the parts inside are trying to tell me different ways of how to handle the situation.” This patient was a victim of incest and still felt the abuser watching her.

Figure 9. Resolution phase: Self-portrait by host and satanic alter personality, significant in that this was the first time that these two parts cooperated on paper.

Figure 10. Emergence phase: After 1 year of treatment, the patient has reconnected the known and still frightening underlying parts of herself in this positive image. The shark represents her sexually abusive grandfather.
work the awareness requires. As fear subsides and boundaries melt, however, art movement generally becomes fluid and the process familiar. All work contributes to the eventual emergence of the self.

Summary

The treatment of multiple personality disorder in occupational therapy is so new that therapists may find themselves in similar phases of development along with their patients. The therapist’s reactions to this population and the effect these reactions have on the patient have been noted by a number of authors (Drew, 1988; Gannon & Riley, 1990; Stroh, 1989; Torem, 1988). There are always therapists who deny the existence of multiplicity or who think it is rare. Others discover by accident, experience, or choice that it is not a manipulative contrivance, but rather an authentic survival phenomenon that is puzzling, intriguing, and often frightening. Research on this topic is limited, and various opinions, philosophies, and treatment approaches exist.

Initially, therapists may share their patients’ disbelief and early discoveries. They then become aware of how the disorder could develop and that what appears at first to be bizarre is actually ingenious and lifesaving. They gradually collect all the fragments of the disorder and work to understand their patients’ pain. They may become aware of things they would rather not know and slip back into disbelief.

Resolution of the issue of how to help patients heal and become whole is both exciting and frustrating for the therapist and often seems endless, as it must to the patient. This disorder strains therapists’ own boundaries and challenges their belief systems. Patients’ pain can trigger deep emotions in their therapists, who may have issues of their own to resolve. They do not have clear or easy answers for their patients.

What is now emerging is a collective body of knowledge on multiple personality disorder that is being added to the health care professions. Scientific data, sound methodology, and successful techniques will come forth as this illness is conquered.

The acronym DARE (denial, awareness, resolution, emergence) is appropriate to the diagnosis of multiple personality disorder, because it suggests the patient’s taking a risk, stepping into the unknown, experimenting, and trusting. It necessitates the casting aside of the familiar rules and conclusions of a tormented past and the embracing of the truth and the pain that accompanies it. Only through responding to that pain can patients reclaim their delayed identities and know who they really are. Patients with multiple personality disorder certainly display courage and daring, for they come to know that they must hurt before they can heal and protect themselves. Occupational therapy is ideally suited for the engagement of these patients in expressive tasks that allow for the visibility and validity of their pain as they struggle to be free from the past. There can be no true freedom without pain. Art activity can be an important link in the attainment of that freedom.

Acknowledgments

I am grateful to Akron General Medical Center’s Department of Psychiatry for the opportunity to explore and create treatment possibilities and to its director, Moshe Torem, MD, for his enthusiastic support and guidance.

References


