This paper describes initial occupational therapy interventions with a patient whose condition was diagnosed as multiple personality disorder. The patient was on a short-term 14-bed psychiatric unit. The interventions are based on psychoanalytic (Fidler, 1988) and acquisitional (Mosey, 1988) frames of reference.

Sakheim, Hess, and Cluvas (1988) delineated seven stages of treatment intervention with patients with multiple personality disorder on an inpatient unit and alluded to similar stages of treatment defined by Klufi (1984) and Braun (1984a, 1984b). This paper examines the initial stages of treatment.

The patient described in the present paper was hospitalized five times in 4 years (1985–1989). Her condition was diagnosed as follows (Note: Diagnoses are from the Diagnostic and Statistical Manual of Mental Disorders [3rd ed., rev.] [DSM-III-R] [American Psychiatric Association, 1987]):

- Admission 2 (3/21/86 to 4/16/86). Axis I: Multiple personality disorder, dysthymic disorder.
- Admission 3 (5/19/86 to 5/31/86). Axis I: Multiple personality disorder.

For each admission, the treatment team consisted of a psychiatrist, a psychologist, registered nurses, a social worker, and an occupational therapist. The team provided antidepressant medication and individual psychotherapy; psychological testing (for the first and second admissions); daily individual counseling sessions; 1-hr group therapy twice a day; weekly 1-hr family meetings; daily 1-hr task-oriented occupational therapy group sessions; and weekly 1½-hr emotion identification group sessions (Angel, 1981) as well as individual sessions as required.

The team and unit functions resembled those described by Sakheim et al. (1988); that is, the team assessed the patient and taught the patient and therapists about multiple personality disorder. The unit proved to be a secure holding environment during times of crisis.

Because the patient’s multiple personality disorder was confirmed at the time of her second hospitalization, this paper focuses primarily, but not exclusively, on that period. In the 4-week second hospitalization, the treatment team’s work corresponded to Sakheim et al.’s (1988) first two phases: (a) establishing the diagnosis and (b) helping the patient come to terms with multiplicity. At this time, parts of Sakheim...
Multiple Personality Disorder

Identity can be defined as the condition or fact of being a specific person or thing (Webster’s, 1987). For the patient with multiple personality disorder, becoming and remaining the same person from moment to moment is an elusive, hard-won accomplishment.

References to multiple personality disorder in the occupational therapy literature are increasing (Christensen, 1987; Dawson, 1985; Skinner, 1987). Although it is one of the oldest clinical psychiatric syndromes, the first controlled studies of multiple personality disorder in the general psychiatric literature have appeared only in the last few years (Putnam, 1984).

Multiple personality disorder is classified as a dissociative disorder in the DSM-III-R (American Psychiatric Association, 1987). The disorder’s essential feature is “the existence within the person of two or more personalities or personality states” (American Psychiatric Association, 1987, pp. 269–270). Through the process of dissociation, an unconscious defense mechanism, distinct personalities take control of the host’s behavior. The dissociative transition may occur suddenly or gradually. Dissociation is often “triggered by psychosocial stress or idiosyncratically meaningful social or environmental cues” (American Psychiatric Association, 1987, pp. 269–270). Physical and sexual abuse, including incest, are common to the histories of patients with multiple personality disorder (Wilbur, 1984).

Once multiple personalities have been established as a defense against trauma and stress, treatment must address how the patient uses dissociation to deal with intolerable conflicting feelings (Wilbur, 1984). Dissociation permits unacceptable feelings such as anger and dependence to be banished from the host personality and assigned to alter personalities, so that the host need not experience those intolerable, anxiety-producing feelings. Only persistent work in therapy extinguishes the dissociative response to stress. Intrapsychic conflict resolution permits the fusion, or integration, of the multiple personalities (Wilbur, 1984).

The patient with multiple personality disorder in the early stage is likely to resemble Kluf’s (1984) description; that is, the same individual may experience disparate self-concepts, including different genders, ages, and sexual orientations. They may have separate wardrobes, possessions, pursuits and interpersonal styles. Their values, beliefs, and manifest problems may diverge. Some personalities may have symptoms which others do not experience. Their behavior reflects their inner sense of difference; they may have received completely different diagnoses before the multiple personality disorder was discovered. (p. 22)
Connie to report her father’s behavior to the police. Overwhelmed at the police station, Connie could not speak; thus, no charges were brought against her father. Thereafter, the sexual abuse ceased.

Treatment
Mosey (1970) discussed Fidler’s psychoanalytically based occupational therapy model as including “treatment techniques which are identified as exploring and working through” (Mosey, 1970, p. 24). In her early work, Fidler not only stressed the importance of symbolic content in a patient’s occupational therapy work, but also stipulated that the “process by which an individual completed a task was a basis for personality assessment” (Hemphill, 1981, p. 8). Fidler applied psychoanalytic techniques when evaluating unconscious conflicts encompassing self-concept and identity issues (Mosey, 1970).

Mosey (1970) asserted that Fidler combined psychoanalytic and acquisitional frames of reference in practice. In her Life-Style Performance Profile, Fidler (1998) acknowledged that “factors in the external environment can also inhibit or support the learning and development of skills” (p. 3-36). Among her four critical skill clusters, Fidler detailed psychological functions, including “mastery of feelings with the ability to exercise appropriate expression and control” (p. 3-37). Fidler’s interventions build on psychoanalytic evaluation, among others, to remediate or compensate for skill deficits. Mosey’s (1988) frame of reference ascribes to an acquisitional orientation used after or in conjunction with an analytical frame of reference. Mosey stated that a major limitation of the acquisitional frame of reference is that it “should probably not be used as the initial frame of reference for individuals who have severe . . . psychological dysfunction” (p. 3-60). Perhaps this is because most acquisitional models “usually tap the present rather than past interactions with the environment” (Bloomer & Williams, 1981, p. 259). Mosey described continua of behaviors related to the acquisition of interpersonal skills, including assertiveness, which are pertinent to this case study.

In working with Connie, I drew from both of these frames of reference. From the acquisitional frame of reference, I applied Mosey’s (1988) principles that influence learning as part of a treatment team’s effort to address the patient’s dependency conflict. I used Fidler’s early psychoanalytic occupational therapy theory, as described by Mosey (1970), and provided the patient’s alter personalities with nonthreatening, nondirective tasks through which they could explore their identity issues. The patient’s alter personalities produced artifacts and, through these, revealed their individual behaviors and concerns.

The patient’s behaviors were observed during occupational therapy task and emotion identification groups. In this occupational therapy description of treatment, I discuss the evaluation and emphasize the patient’s identity issues, anxiety defenses, and dependency conflict dynamics.

Evaluation
A mosaic tile task derived from the Goodman Battery (Evaskus, 1981) was used as the occupational therapy performance evaluation for the patient’s first three hospital admissions. Although copying of the mosaic design was omitted, written task instructions were a structured task component to which the patient related. Without the copying process, projective responses were obtained from the patient in the evaluation task. On all three admissions, when Connie performed the mosaic tile task evaluation, her occupational therapy behavior was consistent with the diagnosis of major depression. She was socially isolated and withdrawn from the occupational therapy group, lacked verbal assertiveness skills when she required assistance with the task, and demonstrated constricted affect when anger would have been an appropriate response to task frustration. The mosaic tile task evaluation was administered to Connie only, not to any of her alter personalities. On her fourth hospital admission, Connie was given the Allen Cognitive Level Test (Allen, 1988), on which she scored at Level 6. At this level, “symbolic cues are used to formulate plans that guide motor actions. Future events are anticipated, and behavior is organized” (Allen & Allen, 1987, p. 189).

After Connie’s condition was diagnosed as multiple personality disorder, each alter personality was observed and evaluated as that personality related with various occupational therapy task components, with the occupational therapist, and with members of the occupational therapy group. In retrospect, I recommend evaluating every alter personality as it emerges. Skinner (1987), for example, systematically evaluated a patient by administering the Allen test to each alter personality.

Identity
During her second hospitalization, the patient began using occupational therapy as a place to explore the theme of identity in personal as well as in general ways. This exploration process contributed to the establishment of the diagnosis and helped the patient come to terms with multiplicity (Sakheim et al., 1988). The patient’s occupational therapy revelations were shared at team meetings.

In the task group setting, two phenomena occurred relative to the patient’s self-identity issue. First, each of the patient’s alter personalities was fasci-
nated with the theme of identity. Second, each alter personality worked on her own task, thus preventing contamination, or the possibility of fusion with other personalities. The identity concerns of the host (Connie) and main alter personality (Linda) are described below.

Soon after admission, in the evaluation task, Connie placed her own pink initial, which was barely discernible, on a background of blue tiles. Connie had just become aware of Linda’s existence after discovering a letter Linda left in their hospital room. Following the discovery, Connie sometimes stated her wish to be Linda instead of remaining Connie, who was depressed. As Connie, the patient was exclusive and reclusive. She sat at a table outside the door of the occupational therapy room, thereby avoiding contact with others. If able to sit with others, Connie was subdued and uncommunicative. She verbally criticized her own work efforts. When the occupational therapy task became too challenging, she became immobilized.

After completing her tile work, Connie chose to continue the focus on her own identity by lettering a wooden plaque with the message, “You Are Hereby Invited to Become No One But Yourself. R.S.V.P.” In future occupational therapy sessions, Connie displayed continued devotion to clarifying the issue of her own identity. One morning, she became aware of her own sexual attraction to other women and verbalized this to the nurse. She seemed to displace this issue later that day when she involved the six-member occupational therapy task group in a discussion concerning her bewilderment over two needlepoint pictures, which she perceived as showing opposite identities. “Is this a dog or a cat? Fruit or flowers? Flowers or fruit?” she asked. She later told me that when she was young, she thought that cats were always female; dogs, always male.

Later in this 3-week hospitalization, Connie elected to monogram a leather key holder. She engraved her first name unevenly, in wobbly letters. A male patient, who was aware of the patient’s alter personality Linda, suggested that Connie add Linda’s name to the reverse side. Connie refused. She explained to the therapist, “That’s what happens when you have make-believe friends,” although she was aware of Linda’s reality at the time.

The patient’s alter personality Linda also created objects with an identity theme. When she chose to make a colorful gravel art picture, she recognized that the flowers in the picture bore her first name. She stated her love for these flowers. She chose bright colors for her work and assessed her completed task positively, without self-criticism.

Linda explored the identity theme in a general way when she created a decoupage of male and female birds as well as two flower species. The flowers were labeled in Latin. She applied the decoupage material freely.

Linda’s task behavior contrasted with Connie’s. She sat comfortably with the group; behaved seductively, both verbally and nonverbally, with a male patient; worked quickly and made decisions with little apparent difficulty; solved problems in her work; and persisted despite challenges in the occupational therapy task.

**Anxiety Defenses**

Dissociation may be viewed as an extreme flight reaction from a perceived anxiety-producing situation. Connie experienced anxiety within the occupational therapy context, especially when she worked with messy media such as paint, glue, and grout, which she could not control and which may have mobilized unconscious anger. When she encountered these media, the patient acted out her psychological discomfort by squirming. This squirming, she later recounted, was reminiscent of panic experienced in her childhood in attempts to escape her father.

During occupational therapy, the patient showed an inability to do a task that caused her minimal to moderate anxiety. In fact, she fled any task that caused her discomfort. Connie did not seem to perceive that she had any choice except flight. She did not seem aware that she could seek support. For this patient, independence was her only alternative.

**Dependence Versus Counterdependence**

Counterdependence involves reaction formation against dependency needs with overcompensation toward independence (K. S. Rao, MD, personal communication, June 1987). Counterdependence can mask a dependence–independence conflict in the patient with multiple personality disorder.

Connie’s conflicts about dependency caused her to adopt counterdependent behavior. She avoided even minimal dependency in adulthood. Dependence seemed inextricably associated with her childhood dependence, vulnerability, and domination and abuse.

Examples of Connie’s counterdependent conflict occurred daily. The most notable example was her expectation that she should independently solve problems that arose in unfamiliar occupational therapy work. As a consequence of that expectation, she frequently became silently overwhelmed. She would appear physically abject, sitting with her head down, in apparent misery. She would become tense and fidgety but could not ask for help.

The goal in occupational therapy was to use the therapeutic relationship and intrinsically rewarding
activities to promote Connie’s awareness that counterdependence did not serve her constructively, but instead, perpetuated isolating and stressful conditions conducive to dissociation. Mosey’s (1988) acquisitional principles, described below, were applied.

**Principle 1: Acknowledgment of the all-important relationship between the therapist and the patient.** I intervened when the patient demonstrated anxiety during the occupational therapy task group. This intervention contrasted with the behavior of the patient’s mother, who had not intervened on Connie’s behalf during the sexual abuse. I provided Connie with the experiential phenomenon of what getting help felt like. This was the first step toward the goal of Connie’s developing verbal assertiveness to deal with anxiety.

**Principle 2: Learning is increased when it begins at the person’s current level.** I watched for Connie’s nonverbal signs of anxiety and offered unsolicited assistance with stressful activity. The patient’s nonverbal communication of her anxiety was rewarded—she received help.

Kluft (1988) cautioned that “an extremely nurturing and supportive therapist may not provide adequate preparation for the give and take of ‘normal’ work and social relationships” (p. 223). Sakheim et al. (1988) also warned, “It is important that a short stay in the hospital does not encourage regression, but rather helps the patient utilize existing strengths” (p. 122).

With this awareness, the occupational therapist who initially meets the patient’s dependency needs uses this intervention briefly as part of a series of planned progressions. From being helped to identify acceptable dependency, the patient is directed to developing normal coping skills to fill authentic dependency and independency needs.

When getting help with occupational therapy activity, Connie displayed a variety of responses that reflected her dependency conflicts. First, she tested my willingness to help her by repeatedly exhibiting the need for attention, as if to validate that help would be available consistently. Conversely, she seemed irritated at times when I did help her, as though she needed to assert her independence after she allowed herself dependence. Sometimes she seemed relieved when I intervened, however. By the end of the 3-week hospitalization, the patient attempted verbal assertiveness exercises with me to obtain supplies she needed. Such verbal assertiveness indicated the patient’s trust that her needs would not be ignored during occupational therapy.

In the verbal emotion identification group, the patient progressed from counterdependently helping others, in the second hospitalization, to exploring who might come to her aid, by the end of the fourth hospitalization. In this way, she experientially determined that although not everyone was capable of helping her (as her mother was not), some persons could help her when she took the risk to reach out, and this risk taking represented progress.

**Principle 3: Reinforcement and feedback as the consequence of action are important parts of the learning experience.** Very important to Connie and her alter personality Linda were their completed occupational therapy products. These products represented tangible rewards made possible by each alter personality’s having relinquished its counterdependent defense enough to receive the therapist’s help with the task. Holding further positive appeal were the actual activity processes, pleasant in themselves. These processes contributed to the patient’s sense of mastery, derived from her abilities to affect the world. In this sense, occupational therapy reinforced the patient’s valued independence.

**Principle 4: Frequent repetition or practice facilitates learning.** The patient was readmitted for the third time after she had failed in her attempt after discharge to live with her mother. She had then returned to her father, and her dissociations escalated. After a few days back on the unit, the patient was able to meet with me to discuss occupational therapy treatment goals, and she demonstrated a developing awareness of how seeking help was difficult for her. It appeared that the patient’s consciousness of this problem had been heightened by my predominantly nonverbal intervention during the second hospitalization. Now, in view of her more clearly identified problem, the patient agreed with my suggestion to choose unfamiliar occupational therapy activities. Unfamiliar tasks were suggested for a specific purpose: to give Connie practice with the behavioral skill of seeking help. Additionally, the total multidisciplinary treatment team consistently rewarded Connie with attention when she verbalized stress. In the protective environment of the hospital, Connie resorted to dissociation less frequently.

**Follow-Up**

By the patient’s fourth hospitalization, her dissociations had increased alarmingly. Precipitating circumstances included her first husband’s death. She was overwhelmed with his death and also with her children’s problems. Additionally, because of the dissociations, she was in danger of being harmed by one of her alter personalities. At the encouragement of myself and others, the patient agreed to voluntary rehospitalization.

During the patient’s fourth hospitalization, three additional personalities became accessible to the treatment team, thereby expanding the patient’s psychodynamic picture. Skinner (1987) said that “new
alters appearing in the clinic is therapeutic, not a sign of regression [because] . . . all personalities must be addressed in the psychotherapeutic process prior to fusion” (p. 105).

Another positive sign during the fourth hospitalization was the patient’s emerging interalternate awareness. Linda, for example, even worked on one of the other personality’s projects during one session. This behavior contrasted the possessive and exclusive orientation that all of the alter personalities had toward their own work early in the second hospitalization.

Connie, too, shared awareness of other alter personalities’ work when she discussed plans to take their unfinished projects to another hospital where she was transferred. Skinner (1987) cited Dawson’s assertions that alter personalities’ artifacts can “promote interalternate awareness . . . and that such awareness helps move the patient toward emotional acceptance of the [multiple personality disorder] condition” (p. 105).

Although Connie showed such signs of progress by the end of her fourth hospitalization, she had not approached integration of the multiple personalities. Besides the intrapsychic complexity, environmental factors contributed to making psychotherapy especially difficult for this patient. Such factors included her own parents and siblings, who actively sabotaged her treatment by declaring psychiatry and urging the patient to abandon her efforts at obtaining help. The family seemed frightened by the patient’s involvement with mental health professionals and preferred that she join them in their conspiracy of continued silence. Additionally, the patient’s own children presented her with ongoing, major crises.

Nevertheless, after the fourth hospitalization, Connie voluntarily sought a therapeutic relationship with a psychologist at the mental health center. For a person with strong counterdependent defenses, allowing oneself to depend on a therapist represents a significant, although still tentative, psychodynamic shift. This shift may permit Connie to gain an ally in the long treatment process ahead, because it is only after she experiences abreacts of her childhood traumas and achieves multiple personality integration that she will be prepared for the extensive, crucial postunification work remaining (Kluft, 1988).

Postscript

The patient was readmitted for 2 weeks in April 1989 and attended another emotion identification group, this time on anger. She arrived at the session as an adult alter personality, but quickly dissociated so that she participated for the remainder of the group as 6-year-old Marie.

When Marie emerged she was tearful, distressed, and disoriented. She asked immediately for a hug from me, the group leader. I acknowledged Marie’s tears and fearfulness and eventually explained the group topic to her. The patient allowed me to reiterate that Marie wanted a hug.

Fortunately, on that day, the group consisted of only two other members—adult women who, coincidentally, also had been sexually abused. Two female college student observers were present as well.

Despite having witnessed a dramatic dissociation, the members adapted to their new changed group and accepted my explanation of Marie as being a 6-year-old girl. The members proceeded to interact, effectively regarding Marie as a legitimate participant.

To facilitate the awareness and ownership of anger, I had the group listen to a song that describes avoidance as one way to cope with powerful anger. During the ensuing discussion of the song, Marie disclosed her father’s command that she never reveal his sexual abuse of her and her terror at talking about him in the group. Given much reassurance about her safety within the group, Marie continued to speak and vented direct anger at her father several times, although she became frightened and tearful after these admissions.

The other group members validated Marie’s anger at her father and then shared their own anger at their respective abusers. They accepted Marie’s pain and allowed themselves to become involved with her in a way that put them in touch with their own pain. Each member expressed her own shame, guilt, fear, and anger. The session ended with Marie receiving and enjoying a group hug in a circle.

In contrast to the lessening but still marked counterdependence that the patient’s alter personalities had displayed during previous emotion identification groups, Marie had been able to own her need to be hugged and protected by the group. Marie had been able to explore how isolated and frightened she felt with her anger and to experience that she, a 6-year-old, could break secrecy about the sexual abuse she had experienced.

Summary

I communicated often with the patient’s psychologist during her last hospitalization. As the patient moves slowly toward integration, she and I remain in contact through correspondence and occasional lunch meetings. This friendly relationship provides a much-needed ongoing support system for the patient, which is provided by one who is familiar with her diagnostic picture.

This paper has described early occupational therapy interventions with a patient whose condition has
been newly diagnosed as multiple personality disorder. Skinner (1987) suggested that additional occupational therapy interventions be implemented as the patient improves.

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References


Editor's Note. To continue the Case Report department, we need and welcome reports that document the practice of occupational therapy for specific clinical situations. Guidelines for writing case reports are available from the Editor.