Childhood Sexual Abuse and Multiple Personality Disorder: Emotional Sequelae of Caretakers

Occupational therapists are often among the first members of the health care team to be trusted by the patient with information and questions thought to be taboo, especially those of a sexual nature (Evans & Asrael, 1990). Several articles in this issue of the *American Journal of Occupational Therapy* (AJOT) suggest that occupational therapy provides the patient with a forum in which to disclose secrets such as those associated with childhood sexual abuse and multiple personality disorder. Although it is not within the domain of occupational therapy to diagnose mental health conditions, the experienced, well-educated, observant therapist can provide important information that will contribute to a proper diagnosis. In the case of multiple personality disorder, the earlier a correct diagnosis is made, the sooner an appropriate course of treatment will begin. The purpose of this issue of AJOT is to increase our clinical awareness and understanding of multiple personality disorder and its associated phenomena. We also need to be aware, however, of the possible emotional consequences of working with this population.

Acknowledgment of the prevalence of childhood sexual abuse has been relatively recent. Browne (1990) presented a succinct and enlightening account of Freud’s initial identification of the problem of incest in 1896. Freud’s baffling recanting of his discovery of childhood sexual abuse in 1914 led to his ill-conceived theories of infant seductiveness and childhood sexual fantasies. For nearly 50 years, these theories led the psychiatric community to discount patients’ reports of sexual abuse as imaginary. Only in the past two decades have

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Freud’s initial findings, that the sexual abuse of children is extremely common, been substantiated by investigators (Briere & Runtz, 1988; Butler, 1978; Herman, 1981; Jacobson & Straker, 1981, Justice & Justice, 1976; Rush, 1980).

Similarly, multiple personality disorder, although thought to be extremely rare, was initially investigated with enthusiasm. Twenty-eight cases of multiple personality disorder were reported between 1874 and 1900, and another 33 cases between 1901 and 1944. For many years thereafter, however, few cases were reported. Between 1945 and 1954, “when Thigpen and Cleckly first reported their experiences with Eve, so little had transpired in the field of multiple personality disorder that Eve was believed to be the only living person with multiple personality” (Greaves, 1980, p. 578). Only 13 other cases were reported between 1954 and 1969. Reports were often thought to be the therapist’s creation or the patient’s fraud. Then, between 1970 and 1979, Greaves identified reports of 50 cases of multiple personality disorder. He attributed this increase to improved diagnostic techniques and clinical awareness. Since his article was written, many hundreds of cases of multiple personality disorder have been reported, and although the exact incidence remains unknown, the condition is no longer considered rare.

The linkage between multiple personality disorder and childhood sexual abuse is not casual. Fagan and McMahon (1984) noted, “almost all recent articles on multiple personality speak of childhood abuse, both physical and sexual, as a prime causal factor” (p. 26). Fagan and McMahon were the first to suggest that a relatively common outcome of childhood sexual abuse might be multiple personality disorder. Klufi (1987) believed that as members of the helping professions increasingly acknowledged the high prevalence of child abuse and incest, they also discovered increasing numbers of multiple personality disorder among adult survivors of childhood abuse. He credited the effect of feminism and the increasing numbers of women in psychiatry and psychology with focusing serious attention on multiple personality disorder as a sequel of childhood sexual abuse.

Just as children’s reports of sexual abuse are often still suspect (Baldwin, 1990), so there remains a degree of suspicion and disbelief regarding patients' reports of childhood sexual abuse. For many years, patients were not believed to have been abused as children; it was thought that they were sick people telling their stories to gain sympathy.

The American Journal of Occupational Therapy

967
Regarding multiple personality disorder. According to Kluft (1987), skeptics believe that most reported cases of multiple personality disorder result from the patient's fantasy and confabulation coupled with his or her desire to please the therapist by assuming the characteristics of the disorder. Some believe that multiple personality disorder phenomena are iatrogenically produced through hypnosis; others believe patients are malingering or claiming multiple personality disorder for secondary gain.

Greaves (1980) and Kluft (1987) refuted these suspicions in their excellent discussions. They emphasized that 97% of patients with multiple personality disorder try to hide, deny, or disguise their condition. They also showed that the therapeutic process of remembering and recounting the severe abuse that results in multiple personality disorder is so observably painful for patients as to preclude any reasonable secondary gain. The question of iatrogenesis through hypnosis remains open to discussion. Many of the phenomena associated with multiple personality disorder can be partially reproduced in non–multiple personality disorder controls, and self-hypnosis is clearly, although indeterminately, implicated in multiple personality disorder (Bliss, 1984). Multiple personality disorder itself has not been reproduced in nondysfunctional subjects by hypnosis, despite several attempts (Bliss, 1984; Kluft, 1987). Dawson (1990), in this issue of AJOT, explores the philosophical reasons behind such skepticism.

Suggestions that patients with multiple personality disorder may be fantasizing, malingering, or dissembling for secondary gain are similar to the reasons given for the disbelieving of children and adults who claim to have been sexually abused (Benedek, 1984; Goodwin, 1984; Summit, 1983). The reasons for such disbelief may be related to the emotional effect that survivors of childhood sexual abuse have on their caretakers.

Health professionals may be reluctant to believe that incest or other types of severe abuse have occurred because it challenges their view of the world and how families are supposed to function. They may experience anxiety and depression, and they may be insecure in their observations and unwilling to face the legal procedures and family confrontation that must take place if the child is believed (Goodwin, 1984). Health professionals may fear the possibility of their colleagues' skepticism and suspicion, because many persons still believe both incest and multiple personality disorder are rare (Coons, 1986). Finally, clinicians who have worked with abuse survivors may also suffer from secondary posttraumatic stress syndrome, that is, from exposure to the horrors their patients experienced. The health professional may suffer symptoms similar to the patient's, such as fear, agitation, and rage. These feelings may result in reluctance to accept further disclosures of incest or abuse and in withdrawal from the patient, thereby resulting in suboptimal treatment (Benedek, 1984; Kluft, 1989).

Occupational therapists may find themselves exposed to all of the above situations. Some team members, including psychiatrists and psychologists, may express skepticism about multiple personality disorder, thus making it difficult for the occupational therapist to present information that might support such a diagnosis.

Occupational therapists themselves may find accounts of child abuse, particularly severe and repetitive abuse, difficult to comprehend or accept, or they may find themselves unsettled by such reports. Those working with children may also be concerned about their legal responsibilities if they should produce information suggesting that a child is being abused. Therapists who work with patients with multiple personality disorder certainly will experience some degree of secondary stress related to their patients' abusive histories. This may range from mild stress to incapacitating symptoms (Kluft, 1989).

It is important that occupational therapists avail themselves of community and professional support systems when these situations occur. Occupational therapists may want to join the International Society for the Study of Multiple Personality and Dissociation (mailing address: 5700 Old Orchard Road, First Floor, Skokie, IL 60077), a multidisciplinary association that hosts an annual international conference in Chicago. Audiotapes of most of this organization's conference sessions are available. Additionally, regional conferences are held several times a year and are excellent resources for networking.

Dissociation, a relatively new journal dedicated to scholarly research and discussion of dissociative and multiple personality disorders, is published quarterly (mailing address: Ridgeview Institute, 3995 South Cobb Drive, Smyrna, GA 30080). Many Voices, a bi-monthly publication written for and primarily by people with multiple personality disorder, is also available to therapists and to families and friends of persons with multiple personality disorder (mailing address: PO Box 2639, Cincinnati, OH 45201–2639). Support from other therapists working with similar populations is extremely helpful, and local mental health special interest sections are a useful way to make such contacts.

Lastly, occupational therapists may need to seek personal assistance from a psychotherapist, particularly if secondary stress symptoms become severe or if the therapist finds memories of his or her own abuse beginning to surface. Our profession is 97% female and current statistics suggest that one in four females is sexually abused, so it is quite possible that many members of our profession are adult survivors of sexual abuse. ▲

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