Multiple personality disorder is understood today as chronic dissociative psychopathology that most often develops in response to severe abuse in childhood. The dissociative component is a manifestation of a defense mechanism out of control: The person with a biopsychological capacity to dissociate flees inward from overwhelming abuse or feared abuse. When continuing abuse perpetuates dissociations and they are chained by common affective themes, the foundations of multiple personality disorder are laid. Although the disorder has its roots in childhood, most patients are not diagnosed with this condition until 20 to 50 years of age. Many have received several prior, erroneous diagnoses of mental or physical disorders or both over a period of 7 or more years. Failure of diagnosis is an indication of the multiple factors that contribute to making this a covert disorder. Diagnosis and management begin at the same place: the establishment of trust and therapeutic alliance between patient and therapist.

Multiple personality disorder is a dissociative disorder by classification in the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.) (DSM-III-R) (American Psychiatric Association, 1987) (i.e., ideas, thought processes, and associated mental elements are dissociated from the patient's conscious awareness). The etiology of multiple personality disorder is being increasingly established as dissociative psychopathology that develops posttraumatically in persons who have suffered severe physical, sexual, and emotional abuse or neglect as children (Braun, 1984b, 1985; Braun & Sachs, 1985; Kluft, 1984). The dissociation is best understood as a defense mechanism out of control: dissociative inward flight by a child overwhelmed by abuse becomes, over time, chronic posttraumatic psychopathology (Kluft, 1984).

Incidence

Only in the past decade has multiple personality disorder been recognized as a mental disorder with a statistically significant representation in the U.S. population. From the 18th century through the 1970s, multiple personality disorder was thought to be non-existent, rare, or an artifact of hypnosis or other iatrogenic mischief (Decker, 1986).

Today, independently conducted research studies that have been undertaken since 1980 reveal that 95% to 98% of more than 1,000 patients with multiple personality disorder report a history of child abuse (Braun, 1984a; Braun & Gray, 1986; Kluft, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986; Schultz, Braun, & Kluft, 1985; Schultz, Kluft, & Braun, 1989). Current estimates of the prevalence of multiple personality disorder in the United States are as high as 0.1% of the population. The upsurge in recognition and interest may be due in some measure to dramatically popularized patients such as Eve and Sybil, both subjects of movies. In larger measure, it was the work of a number of psychiatrists throughout the 1970s that won recognition of the disorder in the DSM-III (American Psychiatric Association, 1980). By the time the DSM-III-R (American Psychiatric Association, 1987) was published, many patients with the disorder had been studied, and the 1980 diagnostic criteria for multiple personality disorder were revised to the following:

- The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- At least two of these personalities or personality states recurrently take full control of the person's behavior (p. 272)
A Child Abuse Model

The 3-P model (Braun & Sachs, 1985) characterizes multiple personality disorder as a posttraumatic dissociative disorder (see Figure 1). This model assumes that predisposing, precipitating, and perpetuating factors are all necessary and together are sufficient to initiate development of multiple personality disorder.

Two predisposing factors are requisite: (a) a biopsychological capacity to dissociate, usually identified with high responsiveness to hypnosis, and (b) repeated exposure to an inconsistently stressful environment, as one might find in an abusive family in which a child receives unpredictable nurturing and abuse, often for the same behaviors, from parents or other caretakers.

The precipitating event is almost always a specific, overwhelming, traumatic episode to which the victim responds by dissociating. If such events are not common in the life of a person with dissociative capacity, the result may be a discrete dissociative episode, such as fugue. Not all, or even most, persons who dissociate in response to great trauma, however, develop multiple personality disorder.

The final necessary 3-P condition is that of perpetuating phenomena that link the dissociative episode with a common affective theme. The perpetuating phenomena are interactive behaviors, usually between the abuser and the abused, that result in separate memories for each dissociative episode. The memories are ultimately linked by the patient through the mechanism of common affective themes, such as fear, disgust, and anger. The content of such themes may be, for example, abuse by the abuser or anal sex. The context may be abuse at home or school or alterations in neuropsychophysiological state, heart rate, hormone levels, status of neuronal firing, or a combination of these things (Braun, 1983, 1984a).

After long-term exposure to situations that are inconsistently abusive, the patient begins to develop unique life histories associated with each set of memories. The memories aggregate around common themes, events, or neuropsychophysiological states and are chained together by state-dependent learning (Braun, 1984a). The basic tenet of state-dependent learning is that information that is encoded in one neuropsychophysiological state is best retrieved when the person is in the same or a similar neuropsychophysiological state. This state serves as an association for or activation of thought processes or behaviors. Continued trauma reinforces the chaining of memories and associated response patterns. The different adaptive response patterns become functionally separated by amnestic barriers. Thus, the patient's personality is "split." The patient may be unaware, partially aware, or only suspicious that he or she exhibits inconsistent behavior when different personalities with individual life histories function with executive control of the body at different times.

A Conceptual Model

As noted earlier, dissociation, as a concept in psychiatry, is defined as the separation of an idea or thought process from the main stream of consciousness. First enunciated by Pierre Janet in 1889, the concept dropped from favor for decades when Freud rejected dissociation in favor of repression as a central mechanism of psychic defense (Ellenberger, 1970). Today, dissociation is again regarded as a powerful concept for the understanding of human coping mechanisms. Kihlstrom (1987), a major figure in cognitive psychology, believed that dissociation may hold important clues to the cognitive unconscious.

Dissociation can be graphically illustrated as one extreme on a continuum of awareness. Repression shades into dissociation as an involuntary putting-out-of-consciousness mechanism. Next comes denial, which falls somewhere in the middle of the continuum and can be either pathological or protective.

Next is suppression, a voluntary form of unawareness, that is, a conscious putting-out-of-mind of unpleasant material. Finally, at far left on the continuum is full awareness.

Dissociation itself can also be represented on a continuum (see Figure 2). On the left of the continuum are the normal dissociative phenomena, including hypnosis. Moving to the right, the dissociative phenomena become increasingly pathologic, terminating in the severe dissociative disorders.

The complex phenomena of dissociation are conceptualized in a model in which the processes of behavior, affect, sensation, and knowledge (BASK) function on a time continuum (Braun, 1988a, 1988b). If we continue to define dissociation as a separation of an idea or thought process from, or its insertion into, the mainstream of consciousness, we may use the BASK model to demonstrate that dissociation can occur on any one level or on all levels: on the single level of behavior as automatism or sensation in de-personalization or on two levels of affect and sensation in hypnotic anesthesia. Dissociation may occur in all of the BASK processes at once for a greater or lesser period of time, as in multiple personality disorder. Mental health is represented by congruence of all four BASK levels and confluence over the time continuum.

Multiple personality disorder is characterized by disruption in all four BASK components (see Figure 3). The personalities and fragments (thought processes and behaviors that represent less than full personalities) that are formed by events described in the 3-P model have relatively separate life histories and memories. They have, in a sense, more perceived time in their memory files than can be accounted for in actual elapsed time. A more detailed and complete description of the BASK model has been published elsewhere (Braun, 1988a, 1988b). The model was developed to provide mental health workers with a conceptual aid to the understanding of dissociation, the dissociative disorders, and their treatment.

**Diagnosis**

The diagnosis of multiple personality disorder is missed more often than it is made. Two studies (Braun & Gray, 1986; Putnam et al., 1986) documented that a patient with multiple personality disorder is likely to have had three or more hospitalizations, between three and five erroneous diagnoses, and nearly 7 years in the mental health system before the diagnosis of multiple personality disorder is made.

The accuracy and promptness of diagnosis will probably improve in the future, as mental health workers develop a higher index of awareness for the illness. The consistent pattern of false-negative diagnoses in patients with multiple personality disorder (a disorder of secrecy secondary to child abuse), however, may reflect the nature of the disorder as well as the lack of an index of suspicion by the diagnosing mental health professionals. This secrecy may be partially volitional secondary to shame or guilt or non-volitional (dissociative) and parallels the secrecy seen in the abusive family that created it.

Multiple personality disorder is a secret that the patient often is bound to keep or cannot help but keeping. The roots of multiple personality disorder lie in child abuse, and abuse is almost always a family secret (Goodwin, 1985) that must be guarded; the abused child is coerced and threatened into keeping the secret. The patient with multiple personality disorder usually is aware of blackouts and lost time in his or her life, often believing that that is how everyone experiences the world. The patient is sometimes aware of inconsistent behaviors that lead others to see.
him or her as an odd person; the patient develops reactive guardedness and resists sharing information that may seem to confirm oddness. The personality interviewed by the therapist at a particular time may not have access to essential historical information that could lead to a diagnosis of multiple personality disorder.

Although multiple personality disorder develops in childhood, its symptoms often remain unrecognized and therefore go untreated until much later in life. The majority of cases are diagnosed when patients are 20 to 50 years of age (Kluft, 1985). A therapist may be led to suspect multiple personality disorder by some of the following characteristic signs and symptoms:

- A history of several psychiatric or medical diagnoses.
- Inconsistencies in physical behavior, for example, voice changes, changes in facial expression, switching in right or left handedness, substantial differences in clothing worn on the first and subsequent visits, differences in hair style and facial makeup on different visits.
- Inconsistencies in accounts of elapsed time.
- Psychophysiologic manifestations, such as headache, anxiety, chest pain, fluctuations in pain threshold (Braun, 1983), or unpredictable responses to medication (e.g., sudden alterations in insulin requirement) (Barkin, Braun, & Kluft, 1986).
- The experiencing of voices inside the head talking to one another or to the patient; the schizophrenic patient, by contrast, usually experiences voices originating outside the head.
- Multiple personality disorder or other dissociative disorders, or history of abuse in the patient’s family; evidence exists for a transgenerational component in multiple personality disorder (Braun, 1985).

Creativity and relatively high intelligence are often associated with multiple personality disorder. Patients may be artistic and may hold jobs that call for imagination and artistic talent (Schultz et al., 1985).

The differential diagnosis of multiple personality disorder can be difficult because the patient’s signs and symptoms can suggest a number of other diagnoses, such as depression, anxiety, borderline personality disorder, and posttraumatic stress disorder. The voices heard by the person with multiple personality disorder may suggest schizophrenia. The therapist must also be aware that multiple personality disorder and other diagnoses can coexist so as to not to miss the multiple personality disorder because another diagnosis can be made (Coons, 1984).

**Treatment**

In patients with multiple personality disorder, the diagnosis and the beginning of treatment begin at the same place—the development of trust and honesty between patient and therapist. The therapist must be aware of and address four specific issues:

1. The therapist must be consistent, but must also be prepared to be flexible, as appropriate. Patients with multiple personality disorder are conditioned by inconsistent authority figures who may have been both rigid and unpredictable. The patient will distrust the therapist and will attempt to manipulate the therapist into actions that prove his or her unreliability.

2. The therapist must not personalize the accusations made by the patient. The therapist must be aware of countertransference as a potential problem.

3. The patient may set up double-bind situations wherein the therapist can be shown to be uncaring or abusive. For example, if the therapist checks with the patient for missing a treatment session, he or she may be accused by the patient of being too authoritarian. If the therapist fails to check, however, the patient may claim the therapist is uncaring.

4. The patient will question the therapist’s trustworthiness at every point, beginning with initial sessions before diagnosis. Occasionally, a patient will offer to share information with the therapist, provided the therapist will keep it a secret. The therapist must be scrupulously honest with the patient about the obligation to share information with the treatment team. At the same time, information from the team, especially regarding diagnosis, general medical information, and treatment plans, must be fully shared with the patient. This trust in honesty is essential to the therapeutic relationship for all team members.

Figure 4 presents a 13-point approach to treatment of multiple personality disorder, adapted from the continuum of dissociation shown in Figure 2. Although the therapeutic issues are shown to follow one another in order, it should be understood that the therapist may also work back and forth to shore up or potentiate therapeutic progress. Those issues that apply to the occupational therapist are summarized below.

**Trust.** Trust must be reinforced and reestablished at every point in the therapeutic process, as noted above.

**Diagnosis.** The diagnosis of multiple personality disorder is difficult. Once it is made and shared with
the patient, the secret of multiple personality disorder and ultimately of childhood abuse has been exposed. The patient may act out. Although the occupational therapist rarely makes the diagnosis, he or she and the art therapist can be extremely helpful with this issue.

Communication with personalities. After trust is initially established and the diagnosis shared, the psychotherapist may seek to open communication with each personality and personality state. The patient may find communication to be easier and less stressful when expressed in symbolic ways (e.g., through art sculpting) with the occupational therapist than with the methods used by the psychotherapist.

Contracting. Contracting for and evaluation of the patient's safety must be reinforced or carried out by the occupational therapist, especially when the patient is using tools or other sharp objects.

Individual and system history gathering. Much history must be gathered indirectly, especially at first, because of the degree of secrecy the patient maintains. The occupational therapist can greatly aid the primary therapist by helping the patient express this information symbolically and become aware of it while participating in occupational therapy.

Working the issues of each personality. The occupational therapist can help to resolve the questions that must be answered in regard to each personality, that is, who, when, why, where, what, and how (see Figure 4).

Special procedures. Special procedures can be used at specific times under controlled conditions to elicit information and help improve the patient's mastery. These involve the therapist's helping the patient with (a) drawing or mapping the system of personalities (Braun & Sachs, 1986), (b) building sand tray worlds to express emotions or tell secret stories (Braun, 1986; Sachs & Braun, 1986), and (c) occupational therapy, art, music, and movement therapy techniques. Our unit at Rush North Shore Medical Center in Skokie, Illinois, has a playroom with children's toys. The occupational therapist is in charge of this area and helps the patient with multiple personality disorder learn to play and care for his or her internal and external children.

Interpersonality communication. Interpersonality communication should be encouraged as a step toward co-consciousness and integration. The occupational therapist's role is to encourage this during standard occupational therapy activities and especially during play therapy and mapping.

Resolution and integration. Although integration is not the occupational therapist's function, he or she should be aware that integration is usually followed by a period of physiologic adjustment lasting hours to days. The patient may experience decreased coordination and increased sensitivity to stimuli, such as light and sound. More care, therefore, needs to be taken during this period in general and specifically in regard to the activities undertaken.

New coping skills. Practice and solidifying of newly learned skills, especially during occupational therapy outings, helps the patient solidify therapeutic gains. Over time, confusion dissipates and the patient is able to think clearly. The occupational therapist is especially useful in helping to evaluate gains.

Networking and social support groups can help the patient adapt to integration and learn new behaviors. Social support groups are a safe environment in which the patient can rehearse new coping skills. Vocational counseling can help the patient learn new job skills and market existing skills.

Summary

Multiple personality disorder is understood today as chronic dissociative posttraumatic stress psychopathology, usually caused by severe childhood abuse. Braun and Sachs's (1985) 3-P model conceptualizes the etiology as that of predisposition, precipitation, and perpetuation. Predisposition is defined by the biopsychological capacity to dissociate and the child's exposure to an environment in which severe abuse was meted out unpredictably by parents and other caregivers. Precipitation is an overwhelmingly traumatic event that initiates the first use of dissociation as an escape or coping mechanism. Perpetuation occurs when the continuing abusive phenomena link subsequent dissociative episodes with a common affective theme, eventually resulting in separate memories for each. Over time, the patient begins to experience discrete life histories for each set of memories.

The 3-P model is similar to Kluft's (1984) 4-factor model. The primary difference is Kluift's addition of the fourth point, that is, lack of an environment where the abused child can heal between abusive episodes. This fourth point falls under perpetuation in the 3-P model.
Therapists must be aware that multiple personality disorder begins in the secrecy of family-generated child abuse and is maintained as a secret by the fearful patient. The signs and symptoms of multiple personality disorder can suggest a variety of other mental disorders, and many patients have been misdiagnosed over periods of 7 or more years. A case in which a patient has received numerous misdiagnoses may psychiatrically or medically suggest to the alert therapist that the secret of multiple personality disorder has not yet been appreciated.

Recognition of multiple personality disorder as a psychiatric diagnosis requires an index of suspicion and the establishment and maintenance of trust between therapist and patient. Trust is the key to every effective therapeutic alliance. Only if the patient trusts the therapist will the secret of multiple personality disorder be recognized. Only if trust is maintained with each team member will therapy proceed to meet a patient’s multiple needs as well as the goal of integration. Trust will be challenged with every new revelation in the therapeutic process.

Multiple personality disorder is no longer the rare entity it was considered until recently. The incidence in the U.S. population may be as high as 0.1% (this probably includes a number of dissociative disorder cases). Many more cases must be seen in the context of scientific studies before the incidence is truly known. Consultation and case finding and true interdisciplinary collaboration are helpful in the clinical setting. Treatment of multiple personality disorder can be an exciting and fulfilling challenge if boundaries and limits are appropriately set and maintained. ▲

References


