Expressive Therapy in Conjunction With Psychotherapy in the Treatment of Persons With Multiple Personality Disorder

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

This article examines the prevalence and complexity of multiple personality disorder as well as the contributions that psychiatry and occupational therapy make in its treatment. The value of activity is that it serves as a nonverbal mediator of communication. Activities are also useful in helping the therapist to obtain a patient's history, which is necessary for abreaction (i.e., the patient's reliving and recalling of the original abuse). Abreaction is a precursor to the integration of the abusive memories into the patient's current life.

Prevalence

The past two decades have seen a marked increase in diagnosing of this disorder. It was somewhat more common between 1880 and 1910, then its incidence apparently decreased markedly for many decades. Today, we are seeing an unprecedented increase in cases. This may be due to sociocultural factors that are creating this disorder more frequently or, more likely, to changes in diagnostic practices (e.g., the use of hypnosis) that now reveal multiplicity more capably. Regardless of the cause, mental health and rehabilitation professionals are having to become more aware of this phenomenon.

Along with the increasing prevalence of multiple personality disorder seems to be an increasing complexity of the cases. Whereas in earlier years patients with multiple personality disorder appeared to have dual personalities or at least relatively few alters, they now appear to have larger numbers of alters (Bliss, 1980; Greaves, 1980; Kluft, 1984b; Putnam, Guroff, Silberman, Barban, & Post, 1986).

Mental health and rehabilitation professionals need to address the now not-so-rare multiple personality disorder patient from a fresh perspective. Professionals educated about this disorder can become responsive by helping such patients maximally, without expressing skepticism about the patients' needs. Specifically, occupational therapy may provide special modalities and techniques for treating these patients.

Treatment

Many patients with psychiatric diagnoses are treated primarily with chemotherapy. In fact, many patients
with mental illnesses receive prescriptions for psychotropic drugs from their family physician with no other therapeutic intervention. Medications, however, are almost never effective as the primary treatment of choice with multiple personality disorder patients and may even interfere with the integration process (Barkin, Braun, & Kluft, 1986; Kluft, 1987; Ross, 1984). Consequently, the treatment of these complex patients, who have an average of 13 alter personalities each (Kluft, 1984b; Putnam et al., 1986), requires much time and interaction on the part of the therapists involved. Furthermore, traditional intrapsychic or dynamic therapies are probably necessary but not always sufficient in the treatment of patients with multiple personality disorder. Because this disorder requires difficult and time-intensive treatment (Kluft, 1984a, 1984b), it is essential that expressive therapies with skilled professionals (e.g., occupational therapy) be used effectively. Although individual psychotherapy seems essential to deal with intrapsychic processes, the occupational therapy approach with its practical application of developmental and behavioral principles also seems valuable to encourage productive everyday skills and to help control some of the less acceptable behaviors of the host or alters (Dawson, 1985; Skinner, 1987).

Experts in multiple personality disorder (Kluft, 1984a; Putnam, 1989) have acknowledged the substantial contribution of occupational therapy and recommend the use of expressive therapies to treat these patients. Yet it remains unclear just why activity therapies prove so useful, and how we can maximize their contribution. To illustrate one of the many contributions of activity therapies, I will contrast these therapies with traditional talk therapies, which may rely more on cognitive insight.

**Limitations of Verbal Therapy**

The dissociative mechanism that brings about multiple personality disorder is caused almost universally by severe child abuse. This precipitating factor presumably occurred at an early age and in a secretive manner that prevented the child from adequately expressing or working through the abuse. The abuse may have occurred when the child was preverbal, but even if it did not, the abuser likely told the child that he or she must not talk about the experience, using threats to ensure this secrecy. These admonitions may enhance the abused child’s natural tendency to blame himself or herself (Lister, 1982; Summit, 1983). This personal blame, shame, or guilt occurs in unison with and is enhanced by the abuser’s threats and tends to culminate in an assurance that the abuse will not be revealed or discussed. Hence, the overall stance of those alters of the multiple personality disorder patient who do recall the abuse may be a nonverbal or inarticulate recollection.

**The Use of Activities**

Whereas traditional talk therapies can be effective, they rely on the relatively secondary process mechanisms associated with verbal articulateness. Occupational therapy, with its use of media and activity, has the advantage of bringing into expression more primary processes such as preverbal, nonverbal, and behavioral artifacts the patient is not capable of consciously recalling or talking about. Various activities may be defined as being tremendously affectively charged for multiple personality disorder patients (Coons, 1988; Frye, 1988; Sweig, 1988). Consequently, the expression of unrecalled disturbing primary process material through activity may begin the process of catharsis, or the appropriate expression of intense affect.

**Abreaction**

Putnam (1989) explained the reliving or abreaction of intense emotions as a necessary part of the successful treatment of persons with multiple personality disorder. He discussed the triggering of abreaction “by the recall of suppressed, repressed, or dissociated memories and affects” (p. 237). During the course of psychotherapy, a certain word or image may unknowingly bring about abreactive responses to apparently benign cues (Putnam, 1989). Certainly, patients’ art expressions also hint at a great deal of unexpressed affect (Coons, 1988; Jacobson, 1986). For instance, one alter personality in occupational therapy drew a forest scene with a car and a silhouette. This was later interpreted in psychotherapy with the primary therapist as the context in which the patient had been abducted and violated. The eventual goal of abreaction is for the patient to accept the heretofore forgotten material as actually being a part of his or her life, even though it was lived out by another part of himself or herself. Dawson (1985) discussed the use of products made by the alters in order to make their existence and experience more real to the host. This may be a helpful precursor to the intense work of abreaction, because it allows the host to more readily accept the experiences as his or her own.

Once the scenario of the abreacted material is produced and worked through, it is recalled and processed differently than when it first occurred. The content is accepted as legitimate by the primary therapist and others working with the patient, and the affective expression is now approved rather than punished as it was during the original abuse.
Postabreactive Work

The patient may have a variety of intense feelings following an abreactive process. Furthermore, not all alters have the same feelings towards the abuse or the abuser, so communication among alters is a priority at this time (Putnam, 1989). This may be facilitated through the work of the whole psychiatric team of professionals (Caul, 1984; Kluft, 1987). Continuing teamwork allows the patient to begin to develop a more blame-free perspective of his or her part in the early abusive situations. Only after this exhausting work has been completed can the patient regain and integrate the forgotten past in new ways in order to develop healthier current perspectives.

Conclusion

Occupational therapy, with its use of a wide variety of media and activities, offers a great deal to the team treating a patient with multiple personality disorder. Occupational therapy provides an environment in which the alter personalities may emerge and, through their work and actions, provide evidence of their histories and past trauma. This information can then be used in the process of the host’s recall and abreaction of the events. This abreaction is a necessary step towards the alters’ understanding one another and working together toward agreed-upon goals. Abreaction is also a prerequisite for the reintegration of the host with his or her alter personalities when that type of unity is the goal of treatment. Such dealing with extremely affect-laden material will also enhance mutual understanding and sensitivity among alter personalities when cooperation and mutual tolerance are the desired outcomes. ▲

References


