The number of patients diagnosed with multiple personality disorder has increased rapidly in the last 15 years (Boor, 1982; Greaves, 1980; Putnam, Guroff, Silberman, Barban, & Post, 1986). This condition is extremely complex, requiring prolonged, intensive, numerous, and often complicated treatment techniques (Braun, 1986; Ross & Gahan 1988). Although many specialized treatment centers have been developed, because of the large number of cases now being identified, these patients will frequently be seen by therapists who have no specialization in their treatment (Ross & Gahan, 1988).

The purpose of this paper is to present an overview of the common clinical manifestations of multiple personality and to discuss some general implications for occupational therapists who wish to better understand and relate to patients with this disorder.

Clinical Manifestations

The Original or Presenting Personality

Multiple personality disorder is believed to originate in childhood as a result of severe abuse, especially sexual and physical abuse (Coons, 1986; Wilbur, 1984a). An increasing number of patients with multiple personality disorder are reported to have been childhood and adolescent victims of satanic or sex cult abuse involving extreme, ritualistic sexual and physical torture (Baldwin, 1990; Snowden, 1989). It appears, however, that in most cases, multiple personality disorder is not uncovered or diagnosed until the patient is between 20 and 40 years of age (Kluft, 1984).

The overall ratio of female to male patients with multiple personality disorder has been reported to be between 4:1 and 7:1. It is suspected that many cases of multiple personality disorder in men are not uncovered; rather, these men act out violently and end up in jail rather than in hospitals (Kluft, 1985a; Putnam et al., 1986; Schafer, 1986). The patient with multiple personality disorder whom the occupational therapist is most likely to encounter is a young to middle-aged woman.

The legal personality, that is, the person with the legal name of the body, is also called the original or host personality; this personality may or may not be the same as the presenting personality, or the person who enters therapy (Kluft, 1984). In the present paper, the term patient or patient with multiple personality disorder refers to the legal entity, and the term alter personalities describes all other persons residing within the body.

Older references in the literature describe the host personality as bland, emotionless, depressed, and apathetic. These same references also describe the person with multiple personality disorder as having one or two alter personalities that contrast with...
ful, often the opposite of the host personality (American Psychiatric Association, 1973; Rowe, 1975). This characterization fits the stereotypic description of split personality. It is now readily acknowledged that patients with multiple personality disorder do not conform to this original description but have a wide variety of characteristics and often have many alter personalities. Kluft (1985b) suggested that the average number of alter personalities is 13.

Most adults with multiple personality disorder refer to themselves as we, and rather than calling one of themselves the host, they often use other terms, such as the system, the family inside, my flock, the troops, or my people. Whenever possible, it is important to respect the right of the patient with multiple personality disorder to identify himself or herself and to call that patient and the alter personalities by the name each prefers (Braun, 1986).

It is not the therapist’s responsibility, however, to monitor who is present (i.e., who is in executive control of the body) or out. It is perfectly acceptable to insist that the patient identify who is out, because the alter personalities all share the same body and look the same to the therapist (even if they look different to one another, which is a common phenomenon).

Common Alter Personalities

Child and adolescent alter personalities. These are the most common types of alter personalities and are often the first discovered during therapy (Kluft, 1985a; Punnam et al., 1986; Schafer, 1986; Wilbur, 1984a). Most child and adolescent alter personalities emerged to serve a specific purpose, that is, to endure a specific type of abuse that the host personality could not tolerate or to handle feelings that were unacceptable to the host personality (Bliss, 1984; Wilbur, 1984b). Child alter personalities will often say that they do not know how to play. In fact, they often had limited access to the body, except during abusive conditions, and they truly did not experience play. Another common self-description of child and adolescent alter personalities is that of being unloved or friendless, which is also understandable considering the circumstances surrounding their creation.

In many ways, these alter personalities can be seen as children who are emotionally deprived and experientially developmentally delayed (Braun, 1986). Treatment of the child alter personalities has been suggested as a primary concern for occupational therapists, because of their background in child development (Ross & Gahan, 1988).

Protective or rescuer alter personalities. These personalities emerged specifically to save the host or other personalities from intolerable conditions. They may have literally intervened to fight the abuse or they may have defended themselves through trickery, pretense, or running away. Protective alter personalities can be child or adolescent alter personalities as well as adult personalities, but they are usually perceived as helpers or friends of other alter personalities regardless of their age (Kluft, 1984). During therapy, protective alter personalities tend to be helpful, but they can prove resistive or hostile if they feel that their job of protecting is being threatened (Kluft, 1985b).

Negative or hostile alter personalities. These can include personalities that act as persecutors, perpetrators, avengers, or self-destroyers. Persecutor alter personalities are generally considered to be internalized images of the abuser. The persecutive behavior may be expressed internally, externally, or both, but it is directed toward the self. The host or other alter personalities may report hearing the abuser taunting inside his or her head; this internal abuse may also include pictures of the abuse that are so real that the victim personality may feel that the abuse is actually happening again. Sometimes the persecutor will try to hurt another personality physically by actually cutting, burning, or injuring the shared body (Kluft, 1985a).

All therapists must be aware of the potential for self-injury and must prevent it when possible. Equally important, however, is the understanding that the persecutor personality is vital to the multiple personality system and that even self-injury serves a defensive function.

One explanation for this phenomenon is that during the time of the original abuse, persecutor alter personalities may have been formed by the multiple personality system to ensure compliance with the abuser, when protective alter personalities may have wanted to resist; the persecutor alter personality may have determined that submission to the abuse was necessary to keep the patient from greater harm or even death. Compliance with the abuser may have been enforced by the persecutor alter personality with internal threats or actual injury to the body. Another possible explanation is that the patient found it more tolerable and safer to become the abuser than to remain the victim. Often, until the patient enters therapy, and for some time afterward, the persecutor alter personalities continue these behaviors, which kept the body alive in the past but which now are self-destructive.

Regardless of the nature of the origin of the persecutor alter personality, self-injury seems to serve a number of purposes. Some patients report that it relieves anxiety; others state that by hurting themselves they are avoiding being hurt even more severely by their abusers. Frequently, patients believe that they are bad and deserve punishment. The self-injury allows them some time in which they feel better because they have paid for being bad (Wise, 1988).
A major purpose of therapy is to enable the persecutor alter personality to understand that although such self-destructive behaviors may have been essential in the past, they are no longer necessary. Understanding the purpose of the persecutor alter personality and the rationale for self-abuse is essential to the ultimate cessation of self-injury (Wilbur, 1984b).

Perpetrator alter personalities are usually of two types. The first type is the personality who was forced by the abuser to abuse others and who retains the self-image of abuser, even though he or she no longer behaves abusively. This type is most often seen in the cult victim who is no longer active in the cult. The goals of therapy with these alter personalities include helping them to understand the survival mechanism of the early behavior and to develop a more positive self-image based on that rationale (Snowden, 1989).

The second type of perpetrator alter personality is the personality who actively and currently engages in abusive or criminal behavior. In women, the perpetrator often abuses her children in ways that are similar to her own abuse. The perpetrator personality of men may be involved in assault, rape, or child molestation, often resulting in imprisonment (Kluft, 1985a). Cult victims who remain active in cults usually have a perpetrator personality who is responsible for maintaining the cult involvement.

Like persecutor personalities, perpetrator alter personalities are internalized images of the abuser, usually formed to keep the body alive in response to the threat of injury or in self-defense. Unlike persecutor alter personalities, however, perpetrators direct their abusive behavior externally and seldom attempt to injure other alter personalities or the shared body. Perpetrator alter personality must also be seen as essential to the early survival of the person with multiple personality disorder, however repugnant their origins and their purpose will the therapist be able to help the person with multiple personality disorder achieve more socially acceptable behavior (Wilbur, 1984b).

Internal self-helpers. Internal self-helpers may also be called observers, advisors, or organizers. Not every patient with multiple personality disorder appears to have an internal self-helper, but those who do generally describe this alter personality as seeing everything that happens but not feeling anything. The internal self-helper, first described by Allison (1974), is a rational part of the multiple personality system with controlled or nonexistent emotions; this personality watches all of the alter personalities and their interactions and is able to monitor who did what and who responds best to various kinds of intervention. Internal self-helpers can be extremely helpful during therapy, often offering both insight into and ideas for specific interactions that will be immensely therapeutic.

Self-destroyer alter personalities are considered special purpose fragments (Braun, 1986) rather than full alter personalities and are generally found only in survivors of cult abuse. Although other patients with multiple personality disorder may have suicidal alter personalities, the self-destroyer has been created by the cult through the use of torture and abuse for the specific purpose of killing the body if it reveals the secrets of the cult (Snowden, 1989).

Usually, self-destroyer alter personalities do not openly reveal themselves. They can be detected by ideomotor questioning if it is done skillfully and appropriately. This kind of inquiry involves the use of hand signals to talk to all of the personalities simultaneously. It further requires a complete knowledge of the total multiple personality system and its components, which is usually not possible early in therapy. Frequently, the therapy team becomes aware of the presence of a self-destroyer only after the patient with multiple personality disorder attempts suicide, and this attempt is then associated with a discussion of cult abuse. After such a crisis, it is important that a highly skilled psychotherapist conduct a thorough system search to discover the responsible alter personality and any other imbedded self-destroyers in order to provide an adequate level of protection and safety for the patient.

The occupational therapist working with patients with multiple personality disorder needs to be aware of the possibility of cult abuse and to watch for signs, such as drawings suggestive of cult activity. These signs should be reported immediately to the primary therapist, and the occupational therapist must thereafter observe the patient closely for possible self-destructive behavior. The therapist must also remember that not all patients with multiple personality disorder have cult experience, and suicidal gestures can occur in other alter personalities as well as in self-destroyers (Wilbur, 1984b).
psychotherapist. Personality, a lesbian rescuer alter personality, and a heterosexual alter personality as well as adult alter disorder have alter personalities who identify themselves as being of the opposite sex or as having a sexual preference that is opposite that of the host personality. One study reported that this type of alter personality is present in 75% of patients with multiple personality disorder (Putnam et al., 1986). Child and adolescent alter personalities as well as adult alter personalities may be of the opposite sex or sexual preference and may assume any of the other roles of common alter personalities as well. For example, a heterosexual woman with multiple personality disorder (i.e., the host) may have a male child alter personality, a lesbian rescuer alter personality, and a heterosexual male persecutor alter personality. The sexual behaviors of the multiple personality system depend on the preference of the alter personality with executive control of the body, which, if the multiple personality system is uncooperative, can cause serious problems in relationships.

The existence of opposite sex and sexual preference alter personalities may simply be a graphic representation of the range of human sexuality, or perhaps these personalities were created to handle feelings that were perceived as unacceptable by society in general or by the abuser specifically. For example, a woman with multiple personality disorder may create a male alter personality to be strong and aggressive, because she unconsciously feels that she cannot display these traits. Additionally, opposite sex alter personalities may have been created through repeated abuse demands to play a specific sex role during the abuse experience. For example, the little boy who is forced to act, dress, and perform sexually as a little girl may develop a female child alter personality to play that role (M. K. Haddock, personal communication, 1989).

Theorists have focused on helping opposite sex alter personalities understand the implications of sharing a differently sexed body. For example, the 5-year-old male alter personality of a 32-year-old woman may need to be taught that he shares a grown-up woman’s body, so that he does not remove his shirt in public if he becomes warm. Therapy is generally not directed toward correcting sexual identification or preference, but rather toward ensuring behaviors that are internally cooperative and socially acceptable. For example, the female alter personality of a man must either accept that she must use public rest rooms for men or allow a male alter personality to come out to take care of that function.

Alter personalities of a different race. Less common than other alter personalities, but still seen fairly frequently, are alter personalities of a different race than the patient. Reportedly, the alter personality of a different race has been chosen for the stereotypic or imagined qualities of that race. For example, one Caucasian patient with multiple personality disorder had a Native American alter personality, who represented spirituality and other-worldliness (Wilbur, 1984b).

Alternately, the multiple personality system might have created a different race alter personality due to individual perceptions and experiences. For example, the 7-year-old protective child alter personality of a 38-year-old Caucasian woman stated she was Black. During later inquiry, the system’s internal self-helper explained that when the host personality was in grade school, she had had a Black classmate who was the “toughest kid on the block.” This protective alter personality served a survival function, refusing to feel either the abuse or the emotions associated with an extremely traumatic childhood. Another Caucasian patient had a Hispanic child alter personality who spoke Spanish, although she herself could not. She remembered, however, that when she was very young, her only comforters and friends had spoken Spanish.

Older alter personalities. Although most therapists have little difficulty accepting child alter personalities, thinking, perhaps, that anyone can regress, they often have more difficulty believing an alter personality who claims an older age than the patient. Most patients have at least one alter personality who is older than the chronological age of the body. This alter personality is in most cases protective in a motherly or fatherly manner. In other cases, the older age seems related to identification with the abuser, to the extent of taking on the abuser’s age (Schafer, 1986; Wilbur, 1984b). Like alter personalities of a different race or sex, older age alter personalities may take on any of the other alter personality roles, and therapy will then relate to the alter personality’s specific functions in the multiple personality system.

Nonhuman Alter Personalities

Some of the cognitive processes and beliefs that typify the thinking of patients with multiple personality disorder defy rational explanation, yet are deeply, sincerely, and convincingly held by these patients. Although they may seem fantastic and unbelievable to therapists, nonhuman alter personalities are actually fairly common among patients with multiple personality disorder. The two common types of nonhuman alter personalities are animal alter personalities and demonic/mythological alter personalities. These personalities serve as survival or defense mechanisms for

The American Journal of Occupational Therapy

987
the patient and must be recognized as important to the multiple personality system. They must be accepted by the therapist and included in treatment with the other alter personalities.

**Animal alter personalities.** I have found animal alter personalities to be present on several occasions. Some serve the specific function of protecting or comforting the host or other alter personalities and may in this instance be regarded as rescuer alter personalities. Some animal alter personalities understand spoken language, and some can communicate. The therapist should keep his or her primary function in mind and use caution in approaching or touching the patient when an animal alter personality is out.

Animal alter personalities may also be child alter personalities who initially present as animals, usually dogs, because they were trained to act like a dog during sexual abuse, which may have included sexual acts with real dogs. These child alter personalities can usually speak and often express confusion over whether their identity is that of a dog or a child. It is important for the therapist to reinforce the humanity of these alter personalities, because to treat them as animal alter personalities would be to identify with the abuser. The therapist would not refer to this alter personality as a dog, but as a little boy or girl, or as a child, if the sex is unknown.

**Demonic and mythological alter personalities.** Demonic alter personalities are common among victims of satanic cults, and mythological god alter personalities are common among patients who have extremely strong or fanatical religious backgrounds (Ross & Gahan, 1988; Wilbur, 1984b). Some patients describe this type of alter personality as all-powerful or all-knowing, as saintly or evil. Research suggests that reports of demonic possession may in fact be situations of multiple personality disorder with a demonic alter personality (Greaves, 1980; Watkins & Watkins, 1988). Like the persecutor and perpetrator alter personalities, demonic and mythological alter personalities seem to have been created to provide safety for the body, although the rationale for this particular dynamic may be complex or unclear.

The therapist must once again appreciate the origin and purpose that this alter personality serves and accept its importance to the system. The therapist should be honest in expressing disbelief about the all-powerful or all-evil nature of the alter personality. He or she might say, for example, "I know you believe that you are all-powerful; I know that you are important to the system, but I do not believe that anyone is all-powerful."

**Other Characteristics of Multiple Personality Disorder**

Besides their functional classification, alter personalities have been reported to have a variety of behaviors that are strikingly different from those of the host personality. For example, some alter personalities display different handedness, speak other languages, display a variety of illnesses or symptoms, and may describe themselves as having eyes, hair, or skin of a different color (Kluft, 1985a; Wilbur, 1984b). These behavioral and perceptual differences are often quite striking. Experts have compared samples of handwriting among alter personalities within one patient, for example, and have found them to be as different as those written by two different persons (Kluft, 1984).

Alter personalities have also been noted to exhibit different blood pressures, heart rates, and body temperatures. Some scientific studies of physiological differences have been conducted, but the results are inconclusive, probably due to small sample size (Coons, 1988). Therapists are often impressed with specific manifestations. One patient with multiple personality disorder who had injured her back told me she was able to obtain pain relief by switching to an alter personality who had no symptoms and indeed appeared totally pain-free and functional when she did so.

Alter personalities will sometimes use external objects to symbolize their separateness and differences from other alter personalities in the system. Common objects include collections of hats with a different one worn by each alter personality and various stuffed animals or dolls that are carried around or held during therapy, primarily by child alter personalities.

Becoming aware of and respecting such behavioral differences and cues among alter personalities may be extremely helpful to the occupational therapist in establishing rapport and in obtaining commitment to treatment goals.

**General Implications for Occupational Therapy**

As do all people, patients with multiple personality disorder must assume a number of different roles in their daily lives, and they must live in the present. It is common to find that among these patients, some life roles have been filled by only one of the personalities. Kluft (1986) reported that one of his patients had an alter personality who was responsible for exercising and keeping the body slim.

I know of another patient with multiple personality disorder who had practiced as an occupational therapist, although she was pursuing an advanced degree in an unrelated field. She told me that one of her alter personalities had attended occupational therapy school and had done the required studying. In another case, a patient with multiple personality disorder had two alter personalities who could do her job as well as she could, and they often took turns...
doing her work (D. Weinberg, personal communication, 1989).

Several authors have suggested that daily life, with its demands on the individual to play different roles, serves as a model for the formation of multiple personality disorder (Beahrs, 1982; Bliss, 1984; Watkins & Watkins, 1982). Multiple personality disorder is seen as a defensive and survivalist variation of the normal capacity for segmentation of life activities and stages, but one that is complicated by amnesia concerning episodes of childhood abuse.

As the amnesiac barriers related to the abuse begin to fall, patients with multiple personality disorder become increasingly dysfunctional, often losing their jobs, separating from their significant others, becoming alienated from their friends, and losing custody of their children. Social and self-care skills are often diminished, especially during the early stages of therapy (Kluft, 1984).

A concern with improvement of the patient’s current roles and relationships is both justified and important. The primary psychotherapist who is dealing with heavy trauma and abuse from the past is unlikely to focus much therapy time on such practical and current issues (Ross & Gahan, 1988).

We as occupational therapists target age-appropriate skills and occupations in treatment; we believe that tasks are derived from roles and relationships within the external world and that mastery of those roles and tasks represents psychological and physical health. With a sound understanding of the origins, roles, functions, and purposes of the alter personalities within a patient’s system, occupational therapists can use their singular training to function as an excellent resource for the treatment team and patient.

Summary

I have presented the common clinical manifestations of multiple personality disorder, with an emphasis on the occupational therapist’s understanding of, approach toward, and communication with the patient. This discussion has included descriptions of typical alter personalities and their functions, which is essential to the establishment of rapport and appropriate treatment goals. I have suggested general treatment implications for the occupational therapist. Specific treatment techniques are discussed elsewhere in this issue (Fike, 1990).

Acknowledgments

I thank Mari K. Hadcox, PhD, Lynda Baldwin, MA, OTR, and Suzanne Peloquin, MA, OTR, for their insight and suggestions during the preparation of this manuscript.

Portions of this paper were presented at the 69th Annual Conference of the American Occupational Therapy Association, Baltimore, 1989, and at the World Federation of Occupational Therapy Conference, Melbourne, Australia, 1990.

References


apy. In L. E. Abt & I. R. Stuart (Eds.), The newer therapies: A


