The exact incidence of multiple personality disorder is unknown, probably because of the difficulty involved in the diagnosis of the condition (Kluft, 1987). The number of cases appears to be rising, however, as people with incorrect diagnoses such as schizophrenia, borderline personality, and other personality disorders are being more appropriately identified as having multiple personality disorder (Kluft, 1987; Schafer, 1986).

Multiple personality disorder results from severe trauma and is often described as a form of posttraumatic stress syndrome (Spiegel, 1984). The trauma most frequently associated with this disorder is childhood abuse, especially sexual abuse (Coons, 1986; Putnam, Gurøff, Silberman, Baban, & Post, 1986; Wilbur, 1984a). Current studies suggest that one in four girls will be sexually abused before the age of 18 (Briere & Runtz, 1988; Herman, Russell, & Trocki, 1986). It is unknown how many of these sexually abused children will enter psychotherapy in their adulthood as a result of such abuse. Vasquez (1990) estimated that one in five patients currently in psychotherapy for childhood sexual abuse is apt to be diagnosed as having multiple personality disorder. This astonishingly high number suggests that mental health workers such as occupational therapists will be involved in the treatment of increasing numbers of people with multiple personality disorder. By becoming familiar with the diagnosis and with treatment concerns, the occupational therapist will be better able to assist in treating these patients.

The purposes of this paper are to present an overview of psychotherapy techniques used in the treatment of multiple personality disorder that may affect or be useful in the occupational therapy process and to present a description of specific occupational therapy roles in the treatment of multiple personality disorder.

Psychotherapy

Psychotherapy for multiple personality disorder includes psychoanalysis, Jungian psychotherapy, cognitive therapy, behavioral therapy, or a combination of these (Braun, 1984; Kluft, 1984, 1987; Putnam, 1989; Ross & Gahan, 1988; Watkins & Watkins, 1982, 1988; Wilbur, 1984b). No one type of psychotherapy seems to have emerged as preferable. In fact, rapport, honesty, and trust seem to be far more important than the type of therapeutic process used (Allison, 1974; Braun, 1986; Wilbur, 1984a).

Major goals of psychotherapy for persons with multiple personality disorder include (a) reduction of the amnesiac barriers for precipitating trauma, (b) reduction of cognitive, perceptual, and emotional dissonance resulting from the amnesia; (c) resolution of
emotional conflicts surrounding the traumatic events; (d) understanding of the effect of the trauma and amnesia on current life and behavior; (e) establishment of internal cooperation; and (f) resumption of a socially acceptable and personally satisfying life-style (Beahrs, 1982; Braun, 1986; Kluft, 1984; Wilbur, 1984b). Integration, or fusion, that is, the unification of the personalities into a single entity, is not necessarily the goal for all patients with multiple personality disorder. Internal cooperation and a satisfying life, however, are goals for everyone (Kluft, 1987; O'Brien, 1985; Putnam, 1989).

These goals are extensive and complex, as is the course of treatment for patients with multiple personality disorder. One study reported that patients with multiple personality disorder spend an average of 6 years in treatment before their condition is correctly diagnosed (Putnam et al., 1986). As the condition is more accepted and recognized, this time lag will likely be reduced. Nonetheless, treatment time after diagnosis remains lengthy, averaging 2 to 5 years (Kluft, 1987).

Most patients with multiple personality disorder are treated as outpatients on a one-to-one basis by a psychologist, psychiatrist, or psychiatric social worker. Most patients with multiple personality disorder also require hospitalization at some time during their lengthy treatment process, often during times of crisis, when they or their alter personalities endanger themselves or others. A small number of patients require long hospitalizations of 3 months to several years because of the severity of their dysfunction (Ross & Gahan, 1988). This is especially true of those patients who were involved in cult abuse. They require longer and more frequent hospitalizations and a longer course of therapy, sometimes as long as 10 years (Snowden, 1989).

Most hospitalized patients with multiple personality disorder are treated on a general inpatient unit with other psychiatric patients. The literature suggests that many problems are associated with the integration of patients with multiple personality disorder into the general patient population, including staff splitting, insufficient staffing to provide adequate safety, difficulty in developing adequate programming, treatment group disruption by alter personalities, and other patients’ dissatisfaction with the inordinate amount of staff attention required by such patients (Putnam, Lowenstein, Silberman, & Post, 1984). An increasing number of inpatient units, therefore, are being devoted exclusively to the treatment of multiple personality disorder and other dissociative disorders (Putnam, 1989; Ross & Gahan, 1988).

A few programs for patients with multiple personality disorder include day treatment, specialized treatment programs, and general psychiatric programs. Additionally, some part-time (evening) group programs for persons with multiple personality disorder have been described, although these are generally provided as an adjunct to individual outpatient psychotherapy (Knowlton & Bailey, 1988; Stroh, Lee, & Myler, 1986).

Occupational therapists see people with multiple personality disorder primarily as inpatients, although small numbers of therapists also provide outpatient treatment, day treatment, and private treatment (Skinner, 1987). An increasing number of occupational therapists serve as consultants to psychotherapists and occasionally provide direct treatment to their patients.

Hypnosis and Self-Trance

Hypnosis is a treatment technique used almost universally with patients with multiple personality disorder. Initially, hypnosis may aid in diagnosis through the elicitation and identification of alter personalities. Hypnosis may also help the patient to recall traumatic information that has been hidden behind amnesiac barriers and to communicate between and with alter personalities. Finally, hypnosis may assist the patient with stress reduction, relaxation, and other forms of self-healing treatment, including integration or fusion rituals (Braun, 1984; Caul, 1978; Putnam, 1988; Ross & Gahan, 1988).

According to Bliss (1984), multiple personality disorder itself results from the patient’s ability to engage in self-hypnosis. Persons with this disorder used self-hypnosis to protect themselves and to survive; their memories and feelings related to childhood abuse are hidden under self-hypnotic amnesia. Alter personalities carry the memories of abuse and were considered by Bliss (1984) to be independent trance states. The ability of most people with multiple personality disorder to enter hypnotic states easily, even with the most inexperienced hypnotist, strongly affirms this thesis. Hypnosis during treatment, therefore, uses the patient’s skill or strength to promote healing.

One example of a hypnotic technique used by many psychotherapists is the development of ideomotor hand signals, which is based on the premise that although there are many alter personalities, or ego states, there is only one shared body. Hand signals allow the therapist to talk with the multiple personality system as a whole or with several alter personalities at one time. Some psychotherapists also believe that hand signals access the unconscious and that their use can uncover information about past abuse before any member of the multiple personality system, including any internal self-helper, is aware of it (Braun, 1984).
To establish ideomotor hand signals, the patient enters a light trance; then, the psychotherapist asks the whole multiple personality system, through the shared body, for hand signals to designate yes, no, and stop. For example, a raised index finger might mean yes; a raised thumb, no. Once these signals have been developed, occupational therapists and other members of the health care team may find them useful for communicating with these patients.

The Abreaction Process

According to Braun’s (1988) BASK model, dissociation is characterized by discontinuity in the memory process; behaviors, affects, sensations, and knowledge (i.e., BASK) related to the precipitating trauma have been separated from consciousness, walled off behind a barrier of amnesia. When the amnesiac barriers fall, either spontaneously or with therapeutic direction, the patient remembers not only on a cognitive level, but also on an emotional, sensory, and behavioral level. In effect, he or she relives the trauma. This reenactment is known as an abreaction.

All patients with multiple personality disorder experience abreactions, which may vary from a momentary flash back to the reliving of an abusive incident of lengthy duration. Most psychotherapists try to guide, limit, or work through abreactive issues in a therapeutic setting, as opposed to repressing or preventing the abreaction (Steele, 1989). Occupational therapists rarely engage in guided abreactions, but often observe or even unwittingly initiate an abreaction during therapy. Specific projects or artwork often trigger traumatic memories, causing the patient to abreact spontaneously. Occupational therapists need to recognize abreactions and, more importantly, to learn the safest and most efficient way to help the patient end the abreaction.

A spontaneous abreaction can usually be recognized easily: the patient begins acting as if some past traumatic or abusive event is occurring. He or she may suddenly become frightened and hide under the table; the therapist may find the patient hiding under the bed, crouching in a corner, or kneeling behind a sofa. The patient may also attempt self-injurious behavior, such as scratching, cutting, or biting. Some patients may verbalize in a manner that can help the therapist understand the substance of the abreaction, but such verbalizations are often incoherent.

Although each patient with multiple personality disorder is unique, once a spontaneous abreaction occurs, some general guidelines may be helpful:

1. Always address the alter personality who was most recently in control of the body, and not the legal personality, if that determination is possible. In a crisis, the therapist may instinctively call the original or best-known personality, but this name usually will not elicit that person’s control of the body. Even if the abreacting alter personality is unknown, the most recent known controller of the body seems to have the best possibility of regaining control.

2. Call on helper or protective alter personalities for assistance, if appropriate. The alter personality who is abreacting can be asked to look for another alter personality inside who is considered a strong or helpful person.

3. Be extremely cautious about touching the abreacting person. Touch may be interpreted as coming from the abuser and could result in aggressive acting out. Even well-intentioned, or consoling, touching may further upset the patient. The therapist whose aim is to console should always ask the abreacting patient whether he or she can be touched. The patient may initially refuse, but generally appreciates the offer. The offer may be repeated several times, and the patient may eventually agree to be touched or held. If the patient must be held to prevent self-injury, always inform the patient of this action and explain why it is necessary before touching him or her.

4. Orient abreacting patients to the present. Insist that they open their eyes and look around. Repeatedly identify yourself, the time, and the place.

5. Do not deny the reality of what abreacting patients are experiencing. Instead, agree that the experience is frightening or painful, but indicate that it is a memory and that the abuse or trauma is not happening now.

During periods of intense therapeutic abreactions under the psychotherapist’s direction, the patient may have more frequent spontaneous abreactions. The patient may also have more difficulty keeping track of date, time, and place. Occupational therapists can use all of their traditional tools and recommendations (e.g., calendars, clocks, schedules) to help the patient stay oriented.

Occupational Therapy Processes

Communication Techniques

One of the most striking characteristics of patients with multiple personality disorder is their tendency to be very intelligent, although they may not appear so when extremely dysfunctional (Kluft, 1987). Some part of them will be observing and listening to all of the therapist’s interactions. If one is unsure of which alter personality is out, it is safest to address that per-
sonality with the manners and attitude suitable to addressing any adult. Most child alter personalities do not object to being treated with adult respect, but adults hate being patronized. In the early stages of discovery, that is, of realizing or acknowledging their multiplicity, most alter personalities will not readily emerge, but acknowledgment of these personalities may be useful. For example, the therapist can say, “I know everyone can hear me” or “I want everyone to listen now.”

When comfortable with the idea of separateness among the alter personalities, therapists may temporarily forget that their patient has multiple personalities. A therapist may make plans to do a specific activity with one alter personality, without considering the needs of the others. Similarly, the therapist may agree or argue with one alter personality who criticizes or verbally attacks another alter personality, as though the alter personality under discussion were absent! It must be remembered that all alter personalities are present in some manner when one is. Whether alter personalities are co-conscious, that is, cognitively co-present, is irrelevant. Although therapists must act at all times as if everyone can hear everything being said, they must not get frustrated when one alter personality does not remember or professes ignorance of what was said to another. It must also be remembered that alter personalities are limited to the time and energy available to one body. Therapists must encourage their patients to check inside with everyone else before making substantial plans for activities; this not only enhances internal cooperation, but also allows the therapist to remain impartial.

Occupational therapists do not ordinarily use hypnosis during treatment, and nonhypnotic communication is generally preferred. The therapist may at times, however, need to communicate with the patient under hypnosis. In such instances, the therapist is not really doing hypnosis, but rather, the patient is going into a self-trance. An example of hypnotic communication involves the use of ideomotor hand signals. Occupational therapists may find it helpful to identify the ideomotor signals, if these have been established by the psychotherapist, because they can often facilitate communication. It is usually sufficient to ask the patient if one can talk to the hands. Patients with multiple personality disorder will usually enter a self-trance with no assistance. If they do need help in entering a trance, however, these patients (or their internal self-helpers) can generally tell the therapist exactly what to do to enable them to enter the trance and to come out of it. If no hand signals have been determined, the occupational therapist should discuss this with the psychotherapist before attempting to establish them independently.

Hypnosis may sometimes help a specific alter personality come out. For switching to occur, it is generally enough to ask to speak to a particular alter personality. Some patients, however, may initially find it difficult to switch among alter personalities, and many alter personalities have difficulty emerging during the early stages of a therapeutic relationship. It may be useful to say hypnotic-like phrases, similar to those used for relaxation training, for a few minutes to help the patient enter a self-trance, and then to request that a specific alter personality come out. Most patients or their internal self-helpers will be able to guide the occupational therapist in helping them enter a self-trance, if such assistance is needed.

Evaluation Techniques

The occupational therapy assessment of the patient with multiple personality disorder relies heavily on an initial interview. The reports of others (e.g., a chart review; information from the primary psychotherapist and other team members, family members, and friends) are also quite helpful. Methods of formal evaluation may include the Allen Cognitive Level Test (Allen, 1985; Skinner, 1987), the Role Checklist (Oakley, Kielhofner, Barris, & Reichler, 1986; Sepiol & Froehlich, 1990), and projective art techniques (Frye, 1990).

The evaluation of patients with multiple personality disorder, however, differs greatly from that of other patients, because a single formal evaluation is usually insufficient. The evaluation of the host personality may not accurately reflect the status of any alter personality or that of the multiple personality system as a whole. A comprehensive evaluation would necessarily include an assessment of each of the alter personalities. Psychotherapists have done this occasionally, but more from curiosity or to help determine a legal diagnosis of multiple personality disorder. In such cases, the patient is asked to have several alter personalities complete the Minnesota Multiphasic Personality Inventory (Butcher, 1969), the Rorschach (McNulty, 1971), or other psychological tests. The results of these standardized tests for each personality differ as much as for those between separate individuals. The separate tests have not necessarily contributed to any plans for specific treatment (Bjornson & Reagor, 1988; Coons & Fine, 1988; Lovit & Lefkof, 1985).

Therapists who have worked with patients with multiple personality disorder acknowledge how different each personality can be and that many alter personalities seem to have different needs. Although a separate evaluation for each personality would make treatment planning more effective, this could be an onerous task in the case of a patient with 100 alter
personality. The use of a checklist for each alter personality, as suggested by Sepiol and Froehlich (1990), appears to be an expedient alternative by which one could gather information and plan intervention strategies. Further research is needed in this area.

**Intervention Techniques**

While I was collecting material for this paper, I heard a recurring phrase from therapists who worked with patients with multiple personality disorder: “My patients tell me what to do for them.” This may, in fact, be true of all patients, but it is especially true of patients with multiple personality disorder, who are the best source of information and guidance in their own care (Reagor, 1988). Their insight may be a function either of their multiplicity or of their high level of intelligence. Regardless, the occupational therapist can greatly improve treatment effectiveness by allowing and encouraging the patient to become a full partner in treatment planning.

Through the use of a telephone survey and discussions with 33 occupational therapists throughout the United States who are working with patients with multiple personality disorder, I have compiled the intervention techniques described below. These techniques have been grouped into categories that fall under the Developmental/Occupational Behavior and Analytical Frames of Reference (Mosey, 1981).

**Developmental techniques with child alter personalities.** Several brief references in the literature describe the treatment of child alter personalities through the use of play activities (Braun, 1986; Ross & Gahan, 1988). These references usually warn that child alter personalities must not be permitted to assume excessive control of the body; they should not be allowed out in adult areas or during adult time, for example.

Occupational therapists, myself included, have found that controlling child alter personalities is not a major problem. These personalities are shy and withdrawn and have difficulty coming out except when the patient is alone or in psychotherapy. Yet by definition, the child alter personality is one who has stopped developing at a certain age and who has limited experience except with specific abuse situations. This personality carries powerful memories and emotions but lacks the knowledge or skills to cope with them effectively.

If the goal of treatment of multiple personality disorder is integration, or fusion, into one functional person (Braun, 1986), then integration of a dysfunctional part makes little sense. If the goal of treatment is inner cooperation and a satisfying, functional lifestyle (Beahrs, 1982; Bliss, 1984; Watkins & Watkins, 1982), then the child alter personality will first need to learn what these conditions are.

Occupational therapists, with their knowledge of human development and their recognition of play as the proper work of children, can provide a variety of play and learning experiences to help the child alter personality develop age-appropriate emotional and social skills. When developmental intervention occurs simultaneously with psychotherapy that focuses on the specific abuse that created the child alter personality, this personality acquires new coping skills and new methods by which to resolve internal conflicts and is better able to process the traumatic memories.

As long as the environment is supportive and safe and the child alter personality has trust and confidence in the therapist, he or she should have no difficulty coming out to play. The attention of the occupational therapist is usually the first prolonged positive attention that the alter personality has ever received, and the child alter personality will respond with great warmth and affection to the same kinds of activities that would be effective with any child. Projective techniques, the reading of children’s books together, and symbolic play with toys are extremely useful with child alter personalities and can provide another source of information for the psychotherapist and the other members of the health care team (Ray & Lyn, 1989; Sachs, 1990; Schlatter & Robertson, 1988).

**Leisure and recreation activities for anhedonic alter personalities.** Many alter personalities were created to suffer intolerable conditions of abuse; thus emotions or feelings were detrimental (Wise, 1988). These alter personalities, who may be alexithymic (i.e., without awareness of feeling), anhedonic (i.e., unable to experience pleasure), or both, may be considered developmentally disabled. They do not know how to have fun. As occupational therapists, we support a comprehensive therapeutic plan that incorporates a balance of daily living activities (Mosey, 1981). Psychotherapy for trauma resolution associated with multiple personality disorder is arduous work; occupational therapy can assist the patient in achieving an activity balance through the use of leisure and recreational activities.

In some cases, the alter personality will need to learn specific skills (e.g., crafts, games, exercises); in other cases, the alter personality will need to learn about enjoyment and pleasure both in the abstract and in practice. Many alter personalities report that a recreational activity or exercise also provides a socially acceptable outlet for feelings of anxiety, tension, or anger, that is, a new way of coping with the real world instead of dissociating.

**Projective and self-exploratory techniques.** Some occupational therapists, particularly those who work in
facilities without the services of an art therapist, have used projective and exploratory techniques to greatly enhance the total treatment program of the patient with multiple personality disorder (Frye, 1990). Projective and exploratory techniques may include the use of sand trays (Sachs, 1990), story telling, and drama therapy as well as the more traditional arts, such as painting, drawing, and sculpture. Much information regarding the history of abuse can be uncovered through these techniques, which can be extremely helpful when the occupational therapist works closely with the psychotherapist. Many patients learn to use media to express themselves and to communicate the stories about their past that they cannot yet verbalize.

The therapist who uses projective techniques must observe the patient carefully, because there is a high potential for abreactions during such treatment. Although this is not necessarily a negative occurrence, it could be upsetting to other patients.

Self-care and activities of daily living training. Most people with multiple personality disorder have been functional adults, able to perform normal self-care tasks and tasks of daily living independently and at socially acceptable levels. When the amnesiac barriers fall to reveal histories of shocking trauma, patients with multiple personality disorder become increasingly dysfunctional as they assimilate this new information. They are often unable to take care of themselves or to carry out normal daily activities. Some are impaired to the point of failing to eat, dress, or bathe.

Failure to care for oneself may also occur if a dysfunctional or infant alter personality takes control of the body for long periods of time. This phenomenon often occurs in an inpatient setting, where the regression in self-care may be considered iatrogenic (Putnam et al., 1984). The patient may feel safe enough in the hospital to allow a disturbed alter personality to come out for treatment. During the course of the dysfunctional alter personality’s psychotherapy, the body may not receive proper care.

At other times, a decrease in independence may result from a combination of factors: increased confusion due to jumbled memories, disorientation due to uncontrolled switching of alter personalities, and heightened or depressed awareness of the environment due to adverse reactions from such medications as benzodiazepine (Barkin, Braun, & Kluft, 1986). Many patients have reported that they have difficulty entering large grocery stores or drugstores unaccompanied because the numerous items, sizes, and colors are either overstimulating or distracting.

Occupational therapy may quite appropriately focus on activities of daily living with patients or alter personalities who have deficits in self-care. The therapist can do this by setting specific goals; by using schedules, contracts, and rewards in some cases; and by teaching adaptive and compensatory techniques in others. Additionally, community outings have been identified by many patients as being helpful. For some patients, reassurance that their functional status will improve as they progress through therapy is also quite helpful.

Role management. Role-related problems are most common among patients with multiple personality disorder. Because their multiplicity has been problematic for a long time, that is, their life has been disrupted by uncooperative alters, alters acting out, or long periods of amnesia, these patients will generally have problems maintaining intimate and supportive relationships. Maintenance of a job will have been difficult if not impossible, and raising children may have become overwhelming (Ross & Gahan, 1988; Schafer, 1986).

Conversely, for some people with multiple personality disorder, those Kluft (1986) referred to as high-functioning, roles will have been maintained at least as well as for those persons without multiple personality disorder. These patients will have had jobs or careers; entered into long-term or other satisfying relationships, often with children, and exhibited a wide variety of interests and skills. As their amnesiac barriers begin to fall, however, usually in their late 20s or early 30s, and their multiple personality disorder is revealed, these high-functioning patients experience an increasingly severe degree of dysfunction, which affects every role. Patients often lose their jobs, separate from their significant others, become alienated from their friends, and sometimes lose custody of their children. Relationships with their own parents and siblings, if present, grow exceedingly strained.

Over a period of 6 months, I maintained regular contact with a large group of hospitalized patients with multiple personality disorder. I discovered that most of them lived abandoned and lonely lives. Their isolation is tragic in light of Reagor’s (1988) postulate that when the patient with multiple personality disorder has an external support system, the internal system tends to become more cooperative and supportive as well. Restoration of the patient’s roles and relationships is a vital component of comprehensive treatment. The occupational therapist, as a member of the treatment team, targets age-appropriate skills and occupations; therapeutic tasks derive from real-world roles and relationships. Within the occupational therapy framework, mastery of these roles and tasks represents psychological and physical health (Mosey, 1981).

The occupational therapist can help patients with multiple personality disorder define their critical life...
roles and associated tasks. A level of current or baseline competence can be established. The occupational therapist can then work with the patient and significant others to help clarify the process of therapy and to mediate realistic task negotiations for the different parties in each relationship.

One patient and her significant other, for example, had shared household tasks equally, including the payment of bills. During the course of therapy, however, and perhaps because a number of child alter personalities were processing severe trauma, the patient found she could no longer manage numbers. When it was explained to her and her partner that this was fairly common and temporary during intense therapy, the patient stopped feeling so devastated, and her partner willingly assumed management of the bills. As a trade-off, the patient began taking out the garbage, something which had not been her task, but which she could manage easily. A source of tension went out of the relationship due to accurate information about multiple personality disorder treatment and prognosis as well as rearrangement of tasks.

The occupational therapist may need to suggest activities that spouses, friends, and children can do with particular alter personalities to help these personalities learn about and develop nonabusive relationships. With child alter personalities in particular, this is generally an easy task. By offering suggestions for specific tasks, the therapist helps family and friends get over the initial awkward stage of learning to live with someone with multiple personality disorder.

The education of patients with multiple personality disorder and their significant others is both critical and practical. The patient engaged in difficult processing or abreaction work is apt to have spontaneous abreacts at home or while in the company of friends. By teaching significant others the appropriate ways to help their loved one through the abreaction, the therapist helps them to reduce anxiety and gives them strategies for coping with their distress.

Work is extremely important, particularly because most insurance coverage is available only to full-time employees. Although the prognosis for multiple personality disorder is excellent when compared with many other mental health conditions, the cost of therapy is staggering. Most patients with multiple personality disorder must keep their jobs in order to keep their insurance, even if they must temporarily go on disability. Kluft (1986) recommended that high-functioning patients continue working if possible, and occupational therapy would certainly support this.

I recall an instance in which a person with multiple personality disorder had a good relationship with her employer but was finding some aspects of her work more difficult since her therapy had begun. She asked her psychotherapist to meet with her employer to explain her condition and the therapy process so that her job could be modified temporarily. This patient was fortunate in that her particular skills were highly valued, and her employer was extremely supportive. I am not sure, given the notoriety of multiple personality disorder, that I would recommend that all patients tell their employers of the diagnosis. It is possible, however, to help the patient develop a nondiagnostic description of the historical abuse and the therapy needed to resolve it; such disclosures will usually elicit support among employers. With some patients, occupational therapists may also be able to evaluate job situations and make specific recommendations to the patient for job modifications so that he or she will be able to continue working.

Many patients with multiple personality disorder will have to quit work or go on disability or will be fired. In these cases, the occupational therapist may need to help find work alternatives that contribute to a balanced life. Activities such as gardening, yard work, and favorite hobbies can take the place of paid employment. Other alternatives might include the patient's taking courses at a local college or vocational school, developing a new interest, or writing a journal. To be most effective, the work task must have worklike characteristics; it must require a different sort of energy expenditure from the person's usual leisure activities and a regular (preferably, daily) effort, and it must have a satisfying end product in lieu of pay.

During the initial stages of therapy, patients with multiple personality disorder tend to become more dysfunctional until they uncover the worst of their traumatic memories. One patient with multiple personality disorder referred to the process as an inverted bell curve. The return to functional status is slow and arduous. Activities that are acceptable and beneficial for the patient in the early stages may be ineffective or outgrown in the later stages. Conversely, suggestions related to work or other role development that are rejected early in therapy may be enthusiastically accepted as the patient becomes more functional. The patient's status can be expected to change many times through the course of treatment; occupational therapy interventions must be modified over time to respond to the ever-changing needs that accompany this disorder.

Summary

Many aspects of the psychotherapeutic process for patients with multiple personality disorder will affect occupational therapy interventions. This paper has presented in particular the use of hypnosis and guidelines for work with abreacting patients. Discussion also included various therapeutic strategies, including...
communication and evaluation and treatment methods.

Occupational therapy can serve as a stabilizing force for patients with multiple personality disorder as they progress through psychotherapy. By providing developmental play for child alter personalities and leisure activities for anhedonic alter personalities, occupational therapists can complement arduous psychotherapeutic work by providing balance. Occupational therapists can also reinforce role and task management, provide daily living skills training, and offer assistance related to maintaining employment; these interventions promote the highest possible level of function for the patient with multiple personality disorder.

References


