Use of the Role Checklist With the Patient With Multiple Personality Disorder

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A paucity of occupational therapy evaluation tools exists for use with patients with multiple personality disorder. The Model of Human Occupation (Kielhofner & Burke, 1980), particularly the volition and habituation subsystems within this model, proved useful for the identification of the many facets of patients with multiple personality disorder on a short-term treatment unit. The Role Checklist (Oakley, Kielhofner, Barris, & Reichler, 1986), a tool derived from the Model of Human Occupation, was adapted for use with this population and was found to be beneficial in the identification of common goals held by most of the personalities of each patient with multiple personality disorder. The use of the Role Checklist is illustrated with a case example.

When faced with the dilemma of providing treatment on a short-term unit with a prevalence of patients with multiple personality disorder, we found that the evaluation tool in use, an occupational performance history, did not provide enough information about these patients. Questions were answered only by the personality present at the interview, and the performance history tended to threaten those patients who could not account for gaps of time in their day.

The first author began to use the Role Checklist (Oakley, Kielhofner, Barris, & Reichler, 1986). The checklist helped both her and the patients identify the particular roles that the alter personalities filled as well as the goals that were similar for most of the alter personalities. For example, if three of a person’s alter personalities wished to obtain an education, a contract would be obtained from them to attend daily classes.

The Role Checklist permitted patients to view their alter personalities on paper from an activities perspective. Not only did the alter personalities clearly identify their name, age, sex, work, and marital status, but also past, present, and future role involvement and associated values. Future treatment areas, especially the expressive therapies, were often identified through alter personalities’ indications of areas of interest.

In this paper, we describe our clinical observations and reasoning process in using the Role Checklist with the patient with multiple personality and illustrate its use with a case study.

Literature Review

Braun and Sachs (1985) formulated the 3-P model of multiple personality disorder, which addresses predisposing, precipitating, and perpetuating factors. The first predisposing factor is an inborn capacity to dissociate, which is usually identified by an excellent response to hypnosis. The second predisposing factor is repeated exposure to an inconsistently stressful environment, such as love and abuse from the same caregiver, death of a loved one, or frequent geographic or cultural dislocation. The precipitating factor of serious dissociation is the specific overwhelming traumatic event to which the individual responds by dissociating. Perpetuating factors are interactions with the abuser and enabler that result in separate or dissociated memories linked by a common affective theme. These memories begin to take on a role and adaptive style (i.e., a personality of their own). Different adaptive responses become functionally separated by a barrier of amnesia.

Braun (1986) stressed the importance of treatment that involves ongoing identification of who each
personality is; when, where, and how the personalities were created; why specific personalities were created; and what their function has been and continues to be. These questions, when asked in the 3-P model, can facilitate the evaluation process for occupational therapists. The only reference to occupational therapy evaluation in the current literature was reported by Skinner (1987). She described a synthesis approach to occupational therapy assessment and intervention with the patient with multiple personality disorder. Rather than adopting a single frame of reference, this approach allows the therapist to choose the frame of reference that best suits the patient’s needs. Skinner recommended an initial screening, which includes a chart review, an interview, and administration of Allen’s Cognitive Level Test (Allen, 1985), to provide an evaluation of current level of functioning. This information serves as a basis for the choice of frame of reference, which then guides further evaluation and treatment planning.

Although Skinner (1987) emphasized the need for ongoing assessment of the personality who is present during occupational therapy sessions, her evaluation method does not allow for clear delineation of the varied aspects of different personalities (i.e., differing motivation and functional levels). For example, a score on the Allen test may represent the functional ability of only one of many alter personalities. Additionally, there are a number of functional assessments that the occupational therapist may want to administer, such as the Bay Area Functional Performance Evaluation (Bloomer & Williams, 1987), the Kohlman Evaluation of Living Skills (McGourty, 1979), and the Comprehensive Occupational Therapy Evaluation (Brayman, Kirby, Misenheimer, & Short, 1976). Each test, however, must be administered with the understanding that the test results may reflect the abilities of only the personality attending the evaluation at that point in time. This can misrepresent the patient’s functional level. To obtain a valid picture of performance, the overall functioning of all of the patient’s alter personalities needs to be evaluated over time.

Clinical Reasoning

The importance of the adoption of a reflective stance in occupational therapy practice has been advocated by Rogers (1983), Parham (1987), Gillette and Mattingly (1987), and Cohn (1989). We thus reviewed the decision to administer multiple Role Checklists to patients with multiple personality disorder. According to Rogers (1983), the first question of clinical inquiry during an assessment is, What is the patient’s occupational status? Occupational status involves an indication of an individual’s strengths, areas for change, and motivation for occupation. For the patient with multiple personality disorder, the dilemma is which personality’s occupational status is being addressed.

In resolving this dilemma, we were confronted with what Schön (1987) described as one of “these indeterminate zones of practice where uncertainty, uniqueness and value conflict—escape the canons of technical rationality” (p. 6). Our training had not prepared us for this uncertain, unique situation. Information on multiple personality disorder is not included in occupational therapy textbooks; thus, it was a diagnosis unfamiliar to us.

On an intuitive level, the problem-solving process began with what Schön (1987) described as problem setting, or choosing and naming the things the practitioner will notice. The problem was named as the inadequacy of evaluating only one personality in the patient with multiple personality disorder. Framing the problem, a complementary process to naming the problem, involves the conceptualization of the problem with a plan for action. The problem was framed with an understanding of the need to evaluate the multiple personalities of the patient. Due to the potential for differing goals, values, and interests of the various personalities, an assessment of motivation for occupation seemed especially important.

Parham (1987) stated that “theory is a key element in problem setting and in problem solving” (p. 557). Before working with the patient with multiple personality disorder, we had used the Model of Human Occupation (Kielhofner & Burke, 1980) as a frame of reference to guide the evaluation and treatment of patients. The volition subsystem was assumed to be a good starting point for evaluation because of the potential for conflicting motivation between personalities. Because amnesia, a significant deficit in the person with multiple personality disorder (Coons, 1980), interferes with a person’s ability to maintain consistent habits over time (e.g., a daily schedule), the area of role was important.

In reviewing the questions of the 3-P model, we noted that the Model of Human Occupation could be used to find answers to the who, what, and why questions. The volition and habituation subsystems of the Model of Human Occupation address some aspects of who a personality is and why he or she developed through identification of the roles, values, and interests that each personality carries. For example, the answer to why a patient develops a worker personality that continues to attend work, although functioning has decreased or is nonexistent in other personalities, is that work enables the whole person to survive financially, that is, to pay the bills and to have health insurance. Another example of an answer to the why question is a personality who is developed to hold emotional pain that the core personality cannot toler-
ate. This personality might value expressive modalities to communicate this pain to the therapist and other personalities.

The performance subsystem of the Model of Human Occupation addresses the what question. Evaluating what a person can do is as important to the therapist as understanding how the illness limits the patient's functioning. What the patient wants to do, however (i.e., goals and motivation), is addressed by the volition subsystem.

Through reflection on practice, we realized that it was important to stress the patients' volition and habituation subsystems, because the identification of the roles of various personalities as well as their common values and goals seemed essential to the occupational therapy treatment process.

Because the occupational therapy evaluation tools currently available only provided information about the personality present at the interview, we looked for tools to adapt for use with multiple personalities. Adaptation of the Role Checklist was a process that evolved, not an immediate plan. The following is a description of that process.

Case Study

Amber, a 45-year-old white female whose only son had died in a diving accident, was the first patient evaluated with the Role Checklist. She had a long history of incest and sexual abuse perpetrated by her caregiver. Her condition was diagnosed as depression, posttraumatic stress disorder, and multiple personality disorder. Before hospitalization, she had been functioning well at work, but had not met her responsibilities in her personal life, which resulted in legal difficulties. She was found not responsible due to mental incompetency and was hospitalized for evaluation.

According to Braun and Sachs's 3-P model, Amber's first predisposing factor to multiple personality disorder was her ability to be hypnotized (as supported by her psychiatrist), and the second predisposing factor was her long history of incest and sexual abuse, which was perpetrated by her caregiver. The precipitating factor was unknown, but the goal of treatment was to uncover those memories. The perpetuating factor was Amber's ability to develop two personalities to represent a single caregiver in her life; one holds the caring, kind memories, and the other holds the abusive memories.

On our first meeting, Amber had already completed with another therapist a performance history interview and an interest checklist, tools that were used in this setting. Amber had informed the first author that there was "no way she would do any [expletive deleted] ceramics, so don't waste your time!" The meeting ended shortly thereafter.

Several days later, Amber approached the first author and asked about groups she could join, including ceramics. This personality was soft-spoken and polite, whereas the personality of the previous day had appeared brash and tough. On a hunch, the first author administered another interest checklist. The results were somewhat different from the previous results. More art and domestic interests were highlighted. The first author also administered a Role Checklist. Amber seemed interested in the checklist. Knowing that the diagnosis of multiple personality disorder was known to the patient, the first author asked if the other personalities would each complete a Role Checklist. Six were handed to Amber. When asked if this would be enough, she responded that she hoped so.

One week later, four Role Checklists were delivered through interoffice mail, and one was personally delivered to the first author's office. The first author recognized the angry personality she had met at the first interview during this personal delivery. This personality identified herself as N. N's Role Checklist was considerably different from Amber's.

Amber's past roles, that is, her functioning before hospitalization, included all categories but worker. Her present roles or functioning during hospitalization were reduced to worker and friend, and her future roles (goals) included all but student. She valued all categories except student, even placing a plus mark by caregiver, home maintainer, and friend to show they were more than "very valuable."

N's past roles, however, showed she was never a volunteer, a friend, a hobbyist, or an organization member. Her present roles included caregiver (for self), worker, and student (the patient was not attending any known classes at the time). Her goals, or future roles, included home maintainer (for self only) and caregiver (for self). At this point, N explained that she had enough to do to take care of Amber and was tired of having to "take care of all the others." She further explained that she held information for all the personalities. N's values identified that she was unsure of how friends could be valuable and that working with children might be of interest to her. N's checklist also identified her as being 3 years younger than Amber and married, whereas Amber's checklist showed her as divorced.

C's Role Checklist was the next of Amber's personalities to be reviewed. C identified herself as 16 years old and single. The penmanship was large and her checklist included many exclamation points and "yeas," as if completed by an adolescent. C used X's and check marks to identify no and yes. Of particular note was the lack of the friend role in the past and present and the strong goals of caregiver and home...
maintainer. She indicated everything but friend, family member, and volunteer as very valuable. Music was noted as a valuable hobby and vocation (i.e., teaching music). The goal of caregiver was explained with the word "child" and five exclamation points and was circled repeatedly. Later in therapy it was revealed that the patient had had an incestuous birth at age 13 years, and the baby was placed for adoption. Amber held no knowledge of the pregnancy or birth. C's goal was clearly stated at the bottom of the page as, "Want to be a mother."

P's Role Checklist showed future goals of student, worker, home maintainer, and religious participant. A line was drawn through the role of friend; in subsequent meetings with P, this was explained by the statement that there was "no such thing as a friend." She identified herself as 25 years old and divorced. She explained the age differences among the alter personalities as follows: "All of us grow except C. She is stuck and can't grow 'til she remembers." Art and performing (i.e., singing) were P's goals. Her values showed less than "not at all valuable" for friend and family member and more than "very valuable" for home maintainer and religious participant. She had written "Thank you Jane" at the bottom of the page, because, as she explained, it was the first time a therapist had asked her what she liked to do and not what Amber liked to do.

B's Role Checklist contained personalized embellishments in each category. B identified herself as the worker of the group. She had present friends both at work and in her personal life, yet had no past friends and foresaw no future friends. Her penmanship was neat. Every entry was well explained in written examples and later in person. B was the personality who attended work for Amber and has excelled in that area. Music, once again, was identified as a goal, as were worker, student, caregiver, and home maintainer. The role of friend, although participated in, was not seen as valuable, nor was the role of family member. B did, however, tell the occupational therapist what they need and can handle in treatment and how much information they are ready to reveal. Thus, all personalities should be asked if their Role Checklist can be shared with the core personality. The rationale for the identification of common goals is to decrease the chances for treatment sabotage by alter personalities. The Role Checklist evaluation also serves as a catalyst for the other personalities to show themselves to the occupational therapist, often to explain their answers or to obtain the therapist's reaction to their answers. A personality can never be forced to present itself, yet through the identification of the personalities that are willing to participate with the occupational therapist in a nonconfrontive manner (e.g., through a paper-and-pencil task), a more complete evaluation of the whole patient can be obtained before treatment planning begins.

A major value of the Role Checklist in the evaluation of the patient with multiple personality disorder is that it serves to identify and organize treatment goals of the personalities that are willing to participate with the occupational therapist in a nonconfrontive manner (e.g., through a paper-and-pencil task), a more complete evaluation of the whole patient can be obtained before treatment planning begins.

Clinical Considerations

We attempted the use of the Role Checklist to evaluate a patient's volition and habituation subsystems with 11 patients with multiple personality disorder. Nine patients completed the evaluation, 2 refused, and 1 was not asked due to the violent nature of her alter personalities, who appeared to represent her abusers. Of the 9 patients evaluated, 2 had several personalities work on one Role Checklist and then several more work on another. One patient had all 12 personalities work on one form sheet, making interpretation difficult. Together, the patient and occupational therapist interpreted this as the patient's not being ready to view herself on 12 separate forms—one form made her feel more like a whole person.

We strongly believe that patients will tell the therapist what they need and can handle in treatment and how much information they are ready to reveal. Thus, all personalities should be asked if their Role Checklist can be shared with the core personality. The rationale for the identification of common goals is to decrease the chances for treatment sabotage by alter personalities. The Role Checklist evaluation also serves as a catalyst for the other personalities to show themselves to the occupational therapist, often to explain their answers or to obtain the therapist's reaction to their answers. A personality can never be forced to present itself, yet through the identification of the personalities that are willing to participate with the occupational therapist in a nonconfrontive manner (e.g., through a paper-and-pencil task), a more complete evaluation of the whole patient can be obtained before treatment planning begins.

A major value of the Role Checklist in the evaluation of the patient with multiple personality disorder is that it serves to identify and organize treatment planning for the therapist and patient. Future research might include comparative studies to determine if the use of the Role Checklist produces more goal-achieved treatment planning and implementation than other evaluations with the patient with multiple personality disorder. Other areas of interest may include the development of new evaluations for the unique problems this population presents.
References


