Over the past 8 years, since first confronted with a patient with multiple personality disorder, I have been struggling with treatment approaches for this special population. Initially, I embarked on a literature review, finding a wealth of articles in the psychological and psychiatric literature that assisted me in making clinical decisions. The lack of information in occupational therapy literature motivated me to begin to articulate my knowledge and experience in an attempt to disseminate general information that a practitioner would find helpful in understanding these patients and to suggest an occupational therapy approach. In the present paper, I relate some of the processes that I used in deciding how to treat patients with multiple personality disorder on an acute care psychiatric unit.

Linda was a 25-year-old woman transferred from an area facility after numerous suicide attempts, a long history of self-mutilation, and pervasive recurrent thoughts of hopelessness. Her condition had been diagnosed in her previous hospitalization as borderline personality. Nursing notes from that hospitalization revealed much conflict with staff, numerous incidents of seclusion, and repeated use of restraints. Linda was being interviewed by her attending psychiatrist and had begun exhibiting behavior that appeared dissociative. The psychiatrist’s questions were unfamiliar and odd to me, such as (a) Have you ever found clothing in your closet that you do not recognize? (b) Have you ever found yourself in a location you were unfamiliar with, not knowing how you got there and not knowing the purpose of your visit? and (c) Have you ever found entries in your checkbook that you did not make?

The questions yielded crucial information leading to a diagnosis of multiple personality disorder. Linda had found “hooker” clothes in her closet several months prior to admission. She had been confused and alarmed by this but had not told anyone. She had ended up at an unfamiliar bar in Indiana and had no memory of how she had gotten there, although her car was parked outside. Finally, she had numerous confusing entries in her checkbook for purchases she could not recall, although she did find some of the items in her apartment. Linda also had a large credit card bill that she could not account for.

In the weeks that followed, Linda was informed of her diagnosis. She appeared relieved; incidents that had been making her feel crazy finally had an explanation. Linda was already scheduled for many occupational therapy and art therapy groups. Did this new diagnosis change the treatment plan? I began my literature review at this point. I found many helpful articles in the psychological and psychiatric literature, but nothing published by an occupational therapist. Most authors seemed to prefer outpatient treatment of
patients with multiple personality disorder. In some crisis situations, when level of independent functioning or safety was compromised, hospitalization became indicated, for example, in cases of emergence of new personalities, suicidal behavior and impulses, severe anxiety, violence, and integration and fusion. It appeared evident from the literature that most psychiatrists and psychologists with experience conducting group therapy with patients with multiple personality disorder viewed verbal, cathartic, and coping skill development groups as contraindicated for this population (assuming that these patients' alter personalities had not yet integrated) if these groups included patients with other psychiatric diagnoses. Inclusion of patients with multiple personality disorder with other psychiatric patients seemed to present more problematic situations than therapeutic opportunities for the patient with multiple personality disorder. The authors identified dissociation in groups as potentially harmful. The patient with multiple personality disorder was often accused of lying when information from the group, occurring only minutes before, was not remembered. This often triggered the patient to feel abused by the group members accusing him or her of lying. Additionally, the group process had been interrupted by this series of events, thereby compromising therapeutic outcome for all group members. A few authors, however, reported the use of aftercare support groups and group therapy with patients with multiple personality disorder.

Although some authors disagreed on the outcome of therapy and whether fusion is the desired outcome, most seemed to point to a similar process of therapy. This process can be summarized in the following seven stages:

1. Awareness of the disorder.
2. Intellectual acceptance.
3. Interpersonality communication.
4. Emotional acceptance.
5. Neutralization of destructive alter personalities.
6. Integration/fusion.
7. Development of normal coping skills.

With the consideration of the stages of treatment and contraindications for many groups generally seen in acute care psychiatry, a vital role of occupational therapy began to emerge. Three treatment goals were identified:

1. Provide a safe environment for goal achievement and socialization, which promotes an increased feeling of control over the environment through use of media.
2. Support the patient in intellectual and emotional acceptance of the disorder.

3. Provide consistency in the treatment environment.

In occupational therapy, one can provide a safe environment by offering a nonthreatening, success-oriented task orientation. Here, through exploration and mastery of the media, the patient with multiple personality disorder can gain a sense of control.

The informed therapist can support intellectual and emotional acceptance of this disorder by unconditionally accepting any alter personalities that present. The therapist assesses behavior of all alter personalities, exploring the capabilities and limitations of each. The informed therapist reassures the patient that emergence of new alter personalities is part of the therapeutic process, not a phenomenon to be avoided. The therapist's comfort level raises the patient's comfort level.

Consistency must be looked at closely with this population. Appointments must be kept in a timely fashion and promises followed through. If the occupational therapist is called on to make a clinical decision with which the team may differ, he or she must complete negotiations with staff prior to making that decision known to the patient. Breaches of trust are generally felt as abuse by patients with multiple personality disorder. Ongoing staff communication is advisable, because these patients often experience memory losses that may appear manipulative to staff. In addition to good communication among disciplines, the occupational therapist's role in evaluation requires excellent rapport and consistency in determining who is in a group or interaction. If observations are being made but the therapist cannot articulate whom those observations are attached to, therapy is greatly compromised.

**An Occupational Therapy Approach in Acute Psychiatry**

The occupational therapists' role on an acute psychiatric unit is primarily evaluative. This role has also developed as the primary role of the occupational therapist working with patients with multiple personality disorder in acute care. The assessment emphasis is not meant to limit the role of occupational therapy in general; it might not apply to treatment on a multiple personality disorder unit nor to long-term or outpatient programs. It does, however, offer the acute care practitioner a vital role. Assessment is ongoing throughout the course of treatment. Assessment in task-oriented groups appears to be most productive for patients with multiple personality disorder in the first five stages of treatment. In task groups, behavior and interactions of different personalities can be observed concretely. The therapist observes appearance, habits, speech patterns, task skill, judgment, and feel-
This involvement in meaningful activity assists the patient with multiple personality disorder. The task-oriented treatment environment is structured to be nonthreatening and success oriented. This facilitates the patient’s comfort level, thus more alter personalities tend to emerge spontaneously. The assessment process begins again with the emergence of a new alter personality. The task-oriented treatment environment is structured to be nonthreatening and success oriented.

Craft, social, and recreational activities tend to be task oriented and thus excellent forums for observation. In craft groups, a patient may not recall what project he or she was working on if a different alter personality began the project. The alter personality may not have even met the therapist yet. Each first interaction with an alter personality, therefore, needs to be like a first session with any other patient. The therapist will first need to determine who is present and then orient the alter personality to the group and initiate therapy. If the therapist assumes that this is the same alter personality as the day before and is incorrect, trust is compromised and the patient may begin to feel out of control and experience the treatment environment as inconsistent.

In social and recreational activities, patients with multiple personality disorder often have emerged as organizers and planners. Although their follow-through is inconsistent, they seem to have a positive effect on other patients on the acute care unit terms of motivation and generation of ideas. These experiences have largely been positive for patients with multiple personality disorder, as opposed to other interactions in unstructured time that may not be so positive.

In my experience, patients with multiple personality disorder have generally been excluded from insight-oriented occupational therapy groups. This decision was based initially on the literature review and is now supported by clinical experience. When included in insight-oriented groups such as assertiveness training, stress management, or goal setting, patients with multiple personality disorder generally have not been able to follow the group format and have become agitated, which may stimulate dissociation. The therapist then needs to spend time with the new alter personality that has emerged to orient that personality to the group. This detracts greatly from the group process for other patients, who may accuse the patient with multiple personality disorder of lying or of seeking attention when dissociation has occurred. This is counterproductive for the patient with multiple personality disorder. The treatment environment is then experienced as unsafe by the patient, who may not feel supported by staff. The dissociation has occurred due to an increase in internal stress triggered by an activity aimed at developing coping skills. The patient’s primary coping skill is to dissociate. Thus, the group is reinforcing the use of dissociation, and treatment is compromised.

Occupational therapy groups designed to develop adaptive coping skills become vital for the integrating or fused patient with multiple personality disorder. The focus shifts to relationship building, life skill development, and economic and vocational planning. Nondissociative coping skills need to be developed at treatment stages 6 and 7. This has generally occurred in an outpatient setting and expands the evaluative role used on the inpatient unit.

In summary, during the first five stages of treatment, when the patient’s personalities are emerging, interacting, and beginning to integrate, the occupational therapist maintains an evaluative role, executed primarily through task-oriented groups. When the patient is fused or is seen by the team as being a functional person with multiple personality disorder, coping skill development becomes productive.

Conclusion

I find that keeping abreast of current psychological, psychiatric, and occupational therapy literature is important to continuing development regarding treatment approaches with patients with multiple personality disorder. As an occupational therapist, I have found that working with this population is challenging and gratifying. These clients generally have abusive, shocking, and at times unbelievable histories. At any time in therapy, a sound, a voice, or a task may evoke a painful memory. The therapist must understand the diagnosis and course of treatment and must be willing to remain open-minded. The therapist must be able to tolerate hearing about abusive experiences and must be able to intervene in a situation in which the patient is potentially violent. Ongoing self-education will enhance our therapeutic interventions. Networking is also an important source of education and personal support.

Related Readings


Marmer, S. S. (1980). Psychoanalysis of multiple per-