

THE USE, MISUSE, AND ABUSE OF ART WITH DISSOCIATIVE/ MULTIPLE PERSONALITY DISORDER PATIENTS

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ABSTRACT

Many MPD patients draw or use expressive outlets either spontaneously or with minimal encouragement. The authors speculate that therapists from various professional orientations, regardless of formal knowledge of art as therapy, are being presented with art products and managing as best they can with little direction.

This paper offers the combined perspective of an inpatient occupational therapist and an outpatient clinical social worker. It is a result of our collective professional experience and our reflections about being responsible within the limits of training. We will explore general uses of art by therapists not specifically trained in art as therapy. We will also examine areas in which therapists, whether from inexperience or their own needs, may complicate an already complex and frustrating treatment situation. Finally, we will outline some practical considerations and guidelines for managing art work as a part of therapy.

INTRODUCTION

Therapists treating patients with multiple personality disorder (MPD) or dissociative disorders (DD) are being challenged with unusual treatment issues over and above the routine work of traditional therapy. These patients often demonstrate a high degree of intelligence, creativity, and suggestibility. They have been able to dissociate intolerable, life-threatening experiences into separate manageable sections, diffusing the pain and delegating the burden of memory. Threatened and condemned to secrecy by their abusers, these patients have considerable difficulty verbalizing their pain. Treatment is continually confounded by these injunctions to silence, and the scope of traditional verbal therapies is often limited.

We have noted from our own clinical experience and from observations and conversations with other therapists treating this disorder that most patients draw or use expressive outlets either spontaneously or with minimal encouragement. We speculate that many therapists from various professional orientations, regardless of formal knowledge of art as therapy, are being presented with art products and

managing as best they can with little direction.

The literature acknowledges the value of adjunctive tools with this population, especially the expressive therapies (Braun, 1987; Caul, 1983; Coons, 1986; Kluft, 1985; Putnam, 1989; Ross, 1989). Eighty-five percent of patients with multiple personality disorder show high creativity as well as fluctuations among alter personalities in art styles, poetry, music, and handwriting (Shultz, Braun, & Kluft, 1985). The arts apparently provide an avenue of self-disclosure that appeals to the creative nature of these patients.

Art therapists have long been aware of this appeal. Cohen, a registered art therapist with extensive experience and expertise in the field of multiple personality disorder and the use of art as a primary treatment process, cautions against the random use of art with this population because of the evocative power of media and its potential for mobilizing intense affect (Cohen, 1990; Cohen, 1991; Cohen, 1991; Cohen & Cox, 1989). He strongly urges therapists to be extremely careful and prudent in their use of and reactions to their patients' art work. This stance has been echoed by other art therapists who are documenting the power of art as therapy in multiple personality disorder treatment, but who are also concerned about its general use by therapists not trained in art or media (Jacobson, 1986; Sweig, 1986). Indeed, there is justified reason for concern that therapists—however well-intentioned—may misuse, or even abuse art as a treatment tool. In the absence of hard data about the general use of art as a therapy aide with this population, therapists have a moral obligation to examine their interventions carefully.

This paper is a combined perspective of an inpatient occupational therapist and an outpatient clinical social worker. The occupational therapist is accustomed to activity-based interventions that promote self-expression, independent functioning, and mastery (Frye, 1990). The clinical social worker views her patients' art work as a fact of the therapy process and a valuable source of information about her patients' perceptions and overall experience. This paper is a result of our collective professional experience and our reflections about being responsible within the limits of training. We will explore general uses of art by therapists not specifically trained in art as therapy. We will also examine areas where therapists, whether from inexperience or their own needs, may complicate an already complex and frustrating treatment situation. Finally, we will outline some practical considerations and guidelines for managing art work as a part of therapy.

USES OF ART

The uses of art outlined here are specific to the needs of the patient who has dissociated in order to endure and survive trauma and abuse, and who remains amnesic.

A Way to "Tell"

Probably the most common use of art is to override the injunction given by abusers "not to tell." The secrecy of abuse binds the patient on many levels, and is a formidable obstacle to treatment. Alters are often concrete and one-dimensional. It can be helpful to tell them that drawing is not the same as telling—that they are not going against the rules by drawing. This literal differentiation frees them from their bind and allows the pieces of their stories to be shared.

A Way to Structure Time

Art is also a way to structure time. It is visible evidence of how time has been spent for the patient who loses time. The work of a dissociative patient is to recover and resolve inner knowledge over time, without becoming dysfunctional. Much of a patient's time is spent struggling with inner darkness and unspeakable memories. But, time can also be spent on the creation of calm scenes for a smoothing effect, for being in touch with the beauty of nature and for self-nurture and balance. Art activity assigned as homework can provide structure and continuity between sessions. Setting aside a regular time to do art along with writing can reinforce a therapeutic habit which will be helpful throughout recovery.

Containment/Control

Containment refers to the process of getting the persistent and preoccupying memory out of the head and on to paper or into another form. In this way the patient (especially the outpatient) can maintain the concentration required for daily living while holding the emerging, abreast material until the scheduled therapy session. Control is achieved and felt by working within the limits of the chosen material. Pictures can be large or small, messy or neat, shared or not—to give but a few examples. Art media offer freedom of choice, which is a much needed experience of appropriate power and mastery.

Safe Alternative to Violence

Art provides a safe alternative to self harm or violence. It is an acceptable way to show the strong aggressive and regressive feelings so frequently disallowed in over-controlled children. Art provides an option for releasing rage that reduces the likelihood of further traumatization by restraints, heavy medications, and frightening physical contact. Patients can be told, "Don't do it—draw it." Drawing on paper or using resistive media that involve tearing, breaking, stabbing, pounding, burning, etc., can provide a way to "act out" within the boundaries of "constructive destruction." Art projects depicting powerful and sometimes repulsive or frightening feelings can be folded or covered, and put away until it is safe to view them and deal with the issues. This is a compromise

that respects and recognizes alter's safe expression and shelters the host from "too much too soon."

Foreshadow Coming Events

Art can foreshadow upcoming therapeutic events. These events can involve awareness of past memory, resolution of present conflict, or formation of future goals, depending on the stage of therapy. Patients often draw when they cannot find words to describe their experience. The art itself may represent a pre-verbal anticipation of ripening issues. Artistic expression of surfacing material can also provide a useful focal point. The material is presented, and the therapist can be aware that these issues may need to be dealt with in the very near future. Images can help patient and therapist alike prepare for the difficult work ahead.

Gentle Erosion of Denial

Creative expression assists in the gentle erosion of denial. It takes a long time for patients to make any kind of sense out of what has happened to them. One speculative hypothesis is that under the subtle influence of the intuitive and spontaneous right brain (Edwards, 1979), a patient's art doggedly chips away at the defensive walls of the left brain which logically tries to account for the past. These patients' experiences defy logic. Art can depict the whole picture long before the conscious mind can begin to grasp the facts, let alone accept them. Patients may not be able to alter the reality of their past, but over time, art can help them change the way they look at that past.

Pictorial History

Art products are a pictorial history showing a personal narrative. They may reveal historical events, subjective constructions of a personal myth, the stuff of dreams and fantasies, etc. Nonetheless, they are proof of a connected network of inner experience. Patients' visual expressions complement their writings and verbalizations, filling in the gaps and rounding out the jagged edges of their fragmented perceptions. It is difficult to deny the subjective reality of something so tangible and visible. As painful as their realities may have been, and despite the vicissitudes of memory, patients need the integrating sense of wholeness and continuity that is their unique life's story.

Integration Aide

Art media provide a visible vehicle for promoting integration of separate experience and function. Host and alters alike can observe and participate in a common activity, each contributing individually towards a collective whole. The process of creating together co-operatively, as well as the end product itself, illustrates the relationship of the parts to the whole. At the same time, the concept of unity is reinforced (Torem & Frye, 1991).

POTENTIAL MISUSES OF ART

While the benefits clearly justify the use of art as a therapeutic adjunct with this population, there are avenues for

its misuse through naivete or inexperience.

Losing Sight of Goals

Patients have spent years devising ways to avoid their pain. It is relatively simple for them to adapt their avoidance techniques to their uses of art. It is easy to be seduced by the volume of apparent work into thinking that progress is being made. Roberta Sachs (personal communication, April, 1989) makes the observation that horizontal movement is not necessarily vertical movement. The therapeutic impasses that are inevitable with the dissociative patient may tempt a therapist to go with any kind of movement rather than stay with the issue of impasse. This can lead the novice therapist through the pictorial woods without a compass. Patients may produce relevant content which is fascinating and engaging to their treaters all the while avoiding the work of resolving and integrating the material.

Therapists can also find themselves engaged in "therapeutic voyeurism," distracted by the powerful content of productions, some of which are highly sexual or violent. Unless the treatment is solidly aligned to the goals of unity and effective daily functioning, art work may delay or even confound the healing process.

Over-reacting to Content

Much of the content revealed through non-verbal media is upsetting to view. Examples of unbelievably extreme cruelty, torture, and child abuse, and the even more emotional and horrifying realities of ritual abuse allegations are repeatedly depicted. The patient will notice the reaction of the therapist. If it is overly negative or positive, the patient or alters may believe they must produce sensational, flamboyant art to shock or retain the interest of the therapist. Therapists not used to graphic art may even need to practice under-reacting until the material becomes familiar. Therapists need to monitor their own inner responses so they can make a conscious decision about how to handle them and how to respond to the patient.

Inaccurate Language

Over the course of treatment, many alters within the patient may contribute essential information in the form of pictures or art projects. The therapist's task is to acknowledge the alters enough to invite communication and cooperation, but not so much that the delusion of separation is reinforced. Asking "Who drew this?" or "Did you make this or did someone else?" or "I know you didn't do this, so-and-so alter did..." invites disclaimers of responsibility from the patient and reinforce denial. Even though it is cumbersome to say continually, "The part of you that drew this," or "You drew this even though you don't remember doing it," it is vital not to promote splitting and disownership. Using accurate and carefully chosen language in viewing and discussing art work helps patients talk about and accept the reality of their disowned images.

Inconsistent Limits

Inconsistent limits are just as problematic with art as any other modality of treatment. The abused have experienced poor and ineffective limits and eventually push for whatever they can get. As a result of the early abuse, they have endless needs for gratification that cannot be fulfilled. Patients will look for "enough" in many areas. They will test limits and want special consideration. Patients may experience secondary gain in manipulating staff for an inordinate amount of art supplies, seeking excessive attention for their art work, or avoiding routine activity groups or daily living responsibilities to do art. The dynamics are the same for both in and out patient. The therapist initially says, "Here, let me help you" (rescuer), then begins to feel used (victim), and eventually becomes resentful and moves to "No, you've had enough" (persecutor), withholding materials or attention. Clear rules must be understood by staff and patients. When tempted to go beyond the rules, one should communicate with colleagues, a safeguard essential in maintaining appropriate limits.

POTENTIAL ABUSES OF ART

The potential abuse of art usually involves the therapist's own need and human inclinations. Work with the abused is often exhausting and personally challenging. It is the rare therapist who will not feel needy at times. Therefore, it is important to be forewarned of some possible danger zones.

Personal Gratification

Gifts from patient to therapist are common. Patients need to please and "pay back" the care they do not feel they even deserve. It is difficult to refuse a lovingly, gratefully-done art piece. This is not a black and white issue. The pitfall is to be unduly gratified by the gift, rather than give thoughtful consideration and discussion to the therapeutic impact of such an exchange. Unexamined, the acceptance of art as gifts or even the purchasing of a patient's art, may send mixed messages and promote obligations not helpful to therapy.

Over-Investment

Over-investment in one or more alters due to the therapist's own needs is counterproductive. Some alters are more cooperative and compliant, more talented and creative, more graphic or more prolific. The therapist is likely to be more responsive, either verbally or non-verbally, to one or the other, or the therapist may outright avoid mean, vulgar, or boring alters in favor of the cute, appealing child parts. The patient is also capable of capitalizing on the therapist's selective attention by strengthening or creating an alter whose job is to produce art to please the therapist. There is so much material to be explored with the dissociative or MPD patient, that care must be given to respectfully acknowledge all work produced, reinforcing the importance of the parts to the whole.

Flooding

The overall goal of therapy is to produce an independent, unified person. If a therapist puts too much emphasis on the visual production of traumatic memories before

a solid internal working alliance is created, the patient can easily become flooded and overwhelmed, dependent, and regressed. This may necessitate or prolong hospitalization, cause a flight from therapy, or trigger further repression of important material.

Analyzing/Interpreting

Patients frequently want to know what their pictures mean, and it is easy to fall into the trap of amateur analysis. Art can be understood at three levels: the manifest content, or what anyone can see in the picture; the latent content, which is known only by the patient and may or may not be shared with you; and the symbolic content. Analyzing or interpreting art work directly to a patient can be harmful because (1) the analysis/interpretation may not be true, (2) the patient may not be ready, and (3) if it is *not* true, the patient may believe it because he or she is highly suggestible. Patients sense when they are ready to move to a new level of awareness and find their own meanings when given room to do so.

GUIDELINES FOR USING ART

The following basic guidelines can provide structure and continuity to those who use media as a treatment aide.

- 1) Find out if the patient has ever used expressive modalities in treatment. If not, introduce the concept of using art as a therapeutic task, and see if the patient would be interested in using this tool.
- 2) Establish a verbal or written contract for safety, stating clearly that patients will not harm the therapist, themselves, or the room. They can negotiate to use the materials to express themselves in many ways.
- 3) Ask the patient to agree to sign, date, and keep all art work, emphasizing that art work is similar to journal work and provides continuity as therapy progresses.
- 4) Ask to see whatever the patient has done. Even though the content may be disturbing and unsettling, patients instinctively seek validation and notice if no one acknowledges their work.
- 5) Accept all work non-judgmentally. Alters, especially those who initially present as self-punishing, angry, or cruel, need and test the therapist's acceptance.
- 6) Ask patients to tell you about their work. Open-ended questions using "who, what, when, where, and how" are helpful. Asking "why" usually invites intellectualism.
- 7) Be careful with interpretations as they will likely be your own projections and say more about you than about the patient. Be aware of your own prejudice, bias, and opinions. Own your own reflections and observations, when made, for patients will easily perceive criticism.
- 8) Allow patients to decide what to do with their art. They may want to keep it, hide it, display it, or give it to you for safekeeping. On occasion, a plan may be made to therapeutically destroy or transform a project.
- 9) Encourage patients to continue to use art to help express themselves along with their journals.
- 10) Suggest ideas that expand on a current relevant theme if the patient seeks direction or feels stuck.
- 11) Give patients generous amounts of recognition and reassurance for their courage and bravery in risk-taking and in trusting you.
- 12) Seek professional consultation, ideally from a registered art therapist, to offset potential problems, to remain balanced, and to give direction.

CONCLUSIONS

In the treatment of MPD/dissociative patients, art happens. Mistakes will also happen. There is not one of us who is immune to these areas of potential misuse and abuse. Therapists would do well to be as aware and forgiving of their own errors as they expect patients to be of theirs. Qualified consultation is essential for avoiding or moving out of difficulty and keeping perspective. Whether prepared and informed or not, therapists will find patients using art and are obligated to help them use it in a responsible manner. The uses and guidelines presented here provide a framework for using art as a productive aide in the treatment of dissociative disorders. ■

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