

# THOUGHTS ON THE COGNITIVE PERCEPTUAL SUBSTRATES OF MULTIPLE PERSONALITY DISORDER

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## ABSTRACT

*Although MPD patients typically present to treatment with affective symptoms, trauma-related information is originally encoded in the patients' perceptions and mediated by their cognitions. This paper will describe the dysfunctional assumptive and perceptual categories that form the building blocks of MPD patients' distorted experiences. Perceptual shifting techniques and cognitive reframing will consequently be the recommended interventions prior to therapeutic abreactive work.*

This paper will discuss how the division of consciousness as represented in multiple personality disorder (MPD) is an adaptation to trauma which, phenomenologically and characteristically, is reflected in the ways in which MPD patients feel, think, and perceive. I propose that a dysfunctional perceptual organization underlies their often disjointed cognitions and affects and is, therefore, at the origin of their distorted perceptions of reality. I will first review some relevant features of MPD, followed by a description of MPD patients' affective and cognitive experiences. I will then postulate that some Gestalt perceptual organizing principles subtend initially cognition and then affect, therefore suggesting that perceptual shifting techniques may facilitate the necessary therapeutic abreactive work.

MPD is no longer understood as a rare condition more likely to be described in textbooks than to be found in one's practice (Kluft, 1984). It represents one of the possible adaptations to trauma experienced by a child who is repeatedly abused. As a process, it is initiated by an immediate situation that confronts the child with an acute overwhelming threat (Freud, 1963; Spiegel, 1988). That event propels the individual into a traumatic state that "theoretically" lasts the brief period of time needed for both the psychic equilibrium and the stimulus barrier to be reestablished (Furst, 1978). In children who develop MPD, either because there is not enough time to equilibrate between abuse episodes or because the meaning the assault takes for the child is so unbearable, a pathological psychic equilibrium may emerge. Their initial reactions to trauma reflect the regression and helplessness that these children experience

in the face of uncontrollable danger. Repeated exposure to similarly overwhelming life experiences deluges their overtaxed psyches and forces them to rely on more regressive, primitive defenses such as the dissociative defenses. Though adaptive at its time of mobilization, dissociation does not allow the whole mind to master and work through the traumatic event in order to foster mastery and control by remembering, repeating, and reexperiencing it. Using dissociation as a defense means that some parts of the mind may remember the trauma while other parts repeat it and still other parts may re-experience it. Dissociation actually serves the purpose of helping the child forget the event ever happened. It favors avoidance, inhibition, phobias (Pynoos & Eth, 1985), anxiety, depression (Putnam et al., 1986) as well as revictimization (Kluft, 1989).

The effects of dissociation on the mind of the MPD patient could probably be best captured, at least heuristically, by Braun's (1988) BASK model of dissociation. Braun (1988) proposes that in nondissociators, events are experienced and integrated simultaneously over the four dimensions represented in the acronym (BASK). Nondissociators have Knowledge of the events; they can associate Behaviors to those events, they have Sensations (physical/physiological/proprioceptive) during them and feel Affects as well. On the other hand, an MPD patient can disconnect any or all dimensions of the events; she can allow the event/parts to remain disassociated or recombine them through autohypnosis in a way which may be congruent with dysfunctional patterns of feeling, believing, and behaving. By the time the MPD patient reaches adulthood, her dissociative abilities are out of her control and often maladaptive.

## AFFECT IN MPD

MPD patients' identifying complaints are often presented to the therapist in terms of feelings and moods—and as such can be suggestive of any number of affective disorders. MPD patients speak of feeling depressed, feeling angry for reasons that they do not understand, feeling out of control, or even insisting, "I don't know how I feel."

Problems with mood are central in MPD patients although their affective presentation may be remarkably nonspecific. Many MPD patients present suffering from mood swings (Putnam, 1986). Franklin (1988) notes that multiple mood swings within one therapy session should alert the therapist to the presence of dissociation. Primary affective disorder can be an epiphenomenon of MPD (Coryell, 1983). Bliss (1980) reviews the presenting symp-

toms of 14 patients with MPD. Though these symptoms are experienced across many dimensions, they often revolve around problems in mood and affect. Bliss (1980) documented a history of depression in 100% of his MPD patients, hypomania in 71% and suicide attempts in 91%. Putnam et al. (1986) reported depression in 88%, suicide attempts in 61% and mood swings in 70% of their 100 MPD patients. Insomnia, panic attacks, and phobias were also quite common in their sample.

Acute emotional reactions are often triggered in MPD patients by situations/people/places that, through stimulus generalization, have become associated with their abusers. A strong affective component is present in MPD in which depression and anxiety, often expressed as despair and panic attacks respectively, are the norm. The MPD patient, like many victims of abuse, seems to have a spontaneous affective response to certain stimuli. These responses appear to be conditioned emotional responses (CER) which involve more than temporal contiguity between a conditioned stimulus (CS) (i.e., abuser) and an unconditioned stimulus (US). The work of Rescorla (1972), and Rescorla and Wagner (1972) suggests that in order for the CS to become conditioned, the CS must impart reliable information about the occurrence of the US. When conditioning occurs, this means the outcome the subject anticipates and the CS are contiguous and the association between the two is fairly predictable. Many MPD patients typically report that as children they expended much energy in "figuring out" what it is they either did or said which lead to the abuse; this was an attempt on their part to understand their alleged contribution to the onset of the violence and to eventually thwart it. Therefore, much of the information about the stimulus circumstance has been repeatedly processed at a cognitive level.

## COGNITION AND MPD

The MPD patient's cognitive make up is a defensive by-product of the abuse sustained as a child. Contrary to the initial trauma starting in adulthood, (i.e., for some Vietnam Veterans), the average age of abuse onset for the MPD patient is 4.5 years (Schultz et al., 1987). At that young age, a child is still progressing through the anticipated Piagetian developmental stages; her cognitive structures are coalescing and evolving in a terroristic environment in which she feels held hostage and isolated from peers. The rules that abused children learn and carry with them into adolescence and adulthood are remarkably unhelpful in a nonabuse environment. What they believe to be real and unreal and true and untrue are often distortions by normative standards. Nonetheless, these cognitive distortions form the basis of MPD patients' assumptive world and the grounds upon which they formulate opinions and make decisions.

## DETERMINANTS OF THOUGHT IN MPD

The distortions that form the basis of the MPD patients' cognitive realities stem from faulty information processing of the varieties described by Beck et al. (1979). They lead to the following pathological determinants of thought:

1) dichotomous thinking, 2) selective abstraction, 3) arbitrary inference, 4) overgeneralization, 5) catastrophizing, 6) time distortion, 7) excessive responsibility, 8) circular thinking and 9) mis-assuming causality. Each determinant of thought will be briefly reviewed here in one case example that has been developed more fully elsewhere (Fine, 1989).

*Case History.* The patient, Elayne, is nearly 30 years old. Her MPD was diagnosed four years ago. She had spent the previous six years in a supportive therapy with the diagnosis of schizophrenia, receiving ongoing pharmacotherapy with major tranquilizers. One of the driving forces and major distortions of the Elayne's host personality is an attempt to maintain an idealized view of her father, the abuser. In reality, I have learned that this abusive father started fondling his daughter before the age of one. By her second birthday, there was vaginal finger penetration. Oral and anal intercourse were ritualized by age four, culminating in daily sexual intercourse by age five. Later, to humiliate her further, he included her brother and the family dog. Concomitant physical abuse led to a fractured skull on two occasions.

1. *Dichotomous thinking* (all or none thinking) is a response set in which there is a tendency to classify experiences into one of two extreme categories. Depending on the personality that is being addressed, the thinking may be polarized from the positive extreme to the negative.

The host personality errs in an unrealistically positive description of her father. He is described as a tall, handsome, brilliant professional man. An increasing number of superlatives are employed as the portrayal continues. The host personality's belief system about the father is a distortion . . . and even sounds delusional considering the realities of her life at home. It is as if her distorted idealization of the father is directly proportionate to the degree of his intense devaluation of her.

This example of all or none thinking is only one of the possible determinants of thought encapsulated within the psychological structures of one personality of an MPD patient; other distorted cognitions can be found within that same personality, the theme of the distortion being congruent with the function that personality serves within the system of personalities.

2. *Selective Abstraction* represents a response set in which certain elements or characteristics of an event are taken out of context. Some salient features do not seem to be integrated into the event's perception and therefore can distort its meaning.

One of Elayne's angry adolescent alters refused to interact with a more passive depressed alter who would just "lie there" when the father abused them: "I don't gotta speak to no pushovers." When examining the abuse scene, this angry alter did not perceive the threatening scalpel in the father's hand. The passive alter's stillness, even though it did not prevent the initiation of the abuse, certainly restricted its extent.

3. *Arbitrary Inference* is a response set that involves the drawing of specific conclusions without having the evidence to support them.

The host personality that struggled so hard to maintain an idealized view of the father had no data to substantiate her



claims other than perhaps a few pictures of the father, some clippings about his professional accomplishments, and his diplomas on which to ground her laudatory statements. She had very few accessible recollections of the father around the house.

4. *Overgeneralization and Undergeneralization.* Overgeneralization is a response set in which incorrect conclusions are drawn from a restricted sample or from nonexistent data.

One angry adolescent alter adheres to a syllogism which generalizes her experiences from one man to all men: "My father is bad - he is a man - I cannot trust him therefore I can trust no man." She has chosen to exclude 50% of the population from her interactional repertoire and has been involved in a long series of unsuccessful lesbian relationships.

Undergeneralization is a response set in which incorrect conclusions are drawn because stimulus elements which are by normative standards grouped together are not understood by the MPD patient as belonging to the same stimulus category.

A prostitute alter who was attempting to shift her function within the personality system was having great difficulty understanding my request for discontinuing anonymous "pick up on the street corner or in a bar" sex. After she understood that pick up in a doorway, car, subway (etc.) fell into the identical category, we had to clarify that "blow jobs" though not ending with the letter X in her vocabulary, did in mine.

5. *Catastrophizing and decatastrophizing.* Catastrophizing is a response set where normal stimuli or events are perceived as disasters and elicit extreme evasive responses.

One of Elayne's teenage personalities who used to be forcibly administered diazepam pills by the father before he would rape her, fled from a reputable urban restaurant by climbing out the ground floor window when a woman at an adjoining table took out a pill box.

Decatastrophizing is a response set in which alarming stimuli are misread and downplayed rather than receiving the appropriate attention and deserved response.

A child alter in Elayne took a serious fall which abraded her skin. A staphylococcal infection ensued. The symptoms were ignored until they become so severe as to warrant immediate admission to an intensive care unit with prompt administration of intravenous antibiotics. The children who were afraid of worse pain and doctors (the father was a physician) colluded with one another to obscure the hand (which by this time was the size of a boxing mitt) from the adult alters who would have addressed the problem immediately.

6. *Time distortion* is a response set in which an individual thinks that she is in a different year/season/month/day and acts accordingly.

One alter who was still struggling with the diagnosis of MPD preferred a geoclimatic explanation for her wearing a bulky winter sweater to our July appointment; her last memory was of seeing the Red Apple descending on Times Square on New Year's Eve.

7. *Excessive Responsibility and Excessive Irresponsibility.* Excessive responsibility is a response set which typically leads

to excessive reactions to opportunities for self flagellation, self blame and guilt.

A child personality may persistently berate herself for "not having been a good enough little girl" or an adult alter may be unable to forgive herself her continued sexual involvement with the father through adolescence or adulthood.

Excessive irresponsibility is the converse of excessive responsibility. It often leads adolescent and/or angry alters to behave in ways which perpetuate abuse.

An aforementioned adolescent alter would prostitute herself to "make men pay," ignoring the public health and personal risks in this practice.

8. *Circular Thinking* is a response set in which the premise for the conclusion becomes the conclusion and the conclusion can become the premise, and so on.

One of the child alters commonly repeats: "I am bad, then I am hurt. I am hurt because I am very bad."

9. *Mis-assuming Causality* is a response set in which precursor incidents are disconnected from their consequences and unfortunate connections are presumed between unrelated events.

Because one of Elayne's male personalities found himself in my waiting room one day (a child alter had fled there during a particularly difficult flashback) he assumed it was his appointment time and began to get tempestuous as he argued with another MPD patient. In reality, it was both the wrong time and the wrong day for his appointment.

How MPD patients develop these thought determinants remains unclear, but has been speculated upon elsewhere (Fine, 1989). One must suspect that these cognitions, though trauma based, have evolved because they were adaptive, reinforced, or both. One might speculate that, in MPD patients as in non-MPD patients, the thought determinants originate from perceptions derived from the stimulus environment of the developing child who is trying to make sense of her world.

## PERCEPTUAL ORGANIZATION AND MPD

The human brain is systematic and selective in the way in which it organizes the information it receives into Gestalten (McMullin, 1986). In this section, I postulate that the perceptual rules which govern the non-MPD individual may also be used among the various personalities of the MPD patient, with greater or lesser success. Each personality will scan all inputs, looking for impressions that seem compatible with those already held, excluding those that are not compatible, and weaving all the accepted inputs into a consistent pattern of thought (McMullin, 1986). Each personality creates a consistent, coherent background, which becomes that personality's reality. Each thought must fit neatly within the pattern, and even if the pattern is illogical, it may be valid for that personality as are the associated emotions. In non-MPD individuals, these Gestalten are modified by learning and experience as the child successfully negotiates the various developmental stages. Unlike normal children, MPD children rely on rudimentary impressions. Their distorted impressions remain unchallenged and fixed, rather

than evolving in flexible and situation congruent ways. Their functioning reflects their nonexperimental approach to life. They often think according to trance logic rather than causally.

All aspects of MPD patients' perceptual/conceptual organization may not be equally affected by the traumas they experienced as children. The cognitive distortions and the perceptual dysfunctions are particularly pervasive around perceptions of self, self-other interaction, and other-other interaction. If these deep rooted perceptions were operative in all spheres of MPD patients' lives, the diagnosis would be far easier to make, because their judgement would be consistently poor throughout all aspects of their life.

Precisely how the brain creates these often-damaging patterns is not fully understood, but German Gestalt psychologists collected a series of predictable perceptual processes that have withstood the test of time and experimentation. Although their work is often limited to examining the stimulus elements that lead to a person's perceptual organization, these results can be readily applied to the concepts presented here. These concepts are the following: Proximity, Pragnanz, Similarity, Organizational Set, Direction, Absorption, Resistance, and Stability. A brief review of these perceptual/conceptual organizing principles (McMullin, 1986) will be considered in our case example.

1. *Proximity.* In proximity, elements close together in time or space are associated. One of Elayne's child personalities believed that having her shoes untied led to sexual abuse; as therapy progressed, she came to understand that just being in the house meant that she would be molested and that the untied shoe laces were just incidentals.

2. *Pragnanz.* In Pragnanz, gaps and omissions are ignored so that the fit is stable and closed. This means that if Pragnanz is operative, some personalities should ignore contradictory elements in their irrational beliefs. Elayne's host personality maintained an idealized view of her abuser/father. In the beginning of treatment, she actually had no knowledge of the abuse, although cues were there that she chose to ignore. Her perception of her father as a benevolent individual was so established that even when evidence to the contrary flooded her consciousness as the arduous work of treatment continued, the host rejected the findings.

3. *Similarity.* Similar percepts are grouped together. The angry adolescent alter who used to prostitute herself wanted to make all men "pay." She put all men in the same category without discrimination or, perhaps better said, with equal discrimination.

4. *Organizational Set.* Once the brain forms a percept, it continues organizing incoming data in the same way even though the stimulus pattern changes. The previous example suggests that the angry adolescent alter had one representation of how men were. All men would be lumped into the category MAN regardless of their individual characteristics.

5. *Direction.* This Gestalt principle suggests that today's perceptions are determined by yesterday's perceptions. In MPD (probably more than in any other diagnostic category) this holds true to the point at which some personalities actually maintain the age at which the initial information was encoded. Elayne had a predominance of child alters who

analyzed the world according to age-congruent beliefs and rules.

6. *Absorption.* Stronger percepts/concepts will absorb weaker ones. The MPD patient may give up an established belief if a more potent, simpler and more congruent explanation can be presented. Elayne's host personality more readily accepted the diagnosis of MPD when it explained most of what ailed her rather than her having to rely on a combination medical/psychological diagnosis which was incongruent with her level of functioning (i.e., schizophrenia with epileptic seizures/black-outs/substance abuse and multiple somatic problems with a R/O of Malingering) and led her to be heavily medicated.

7. *Resistance and Stability.* Strong organizational forms resist disintegration. In Elayne, like in other MPD patients, it was important for the information surrounding the trauma to be absorbed and imprinted immediately and accurately, so that when the child was re-abused, she would have access to an already established protective system. These connections are often well rehearsed and overlearned.

At the beginning of treatment for MPD, most of Elayne's personalities were unwilling to even contemplate any shifts in their diagnosis: "Speaking of Johnny come latelys--I have had many crazy labels. . . this is the best one yet--you did not go to school for this one did you? Do you sell snake oil on the side, too?"

Even though her beliefs and perceptions were terribly dysfunctional, handicapped her, and fostered revictimization as an adult, they were familiar and established; as Elayne presently says with cynicism: "This MUST be crazy, it feels like HOME!" It remains to be explored whether there is a one to one relationship between one perceptual concept and one determinant of thought. Indeed, like above, several conceptual Gestalten may feed one determinant of thought. Therefore, to modify one cognition and/or challenge one false belief the therapist may need to help the patient modify several Gestalten.

## TREATMENT IMPLICATIONS

The treatment implications are fairly clear if it is understood that the goals of therapy for MPD patients involve favoring integration between the personalities by fostering a congruence of purpose and motivation between them (Kluft, 1985). The ways in which this congruence is attained is by having the different personalities "talk and feel" with one another as well as communicate with the therapist. Interpersonality communication will facilitate the reconnecting of the four dimensions of the previously described BASK model—reconnections necessary to achieve both completeness and continuity of experience. For the MPD patient to reclaim all aspects of her life, it is imperative that she accept all affects linked to her past and her present. The reuniting of affect to the other three dimensions of the BASK model involves abreactive work which needs to be prepared for both cognitively and perceptually. Abreaction without an a priori cognitive restructuring can be perceived by the patient as retraumatizing; it can foster further avoidance of affect.

Only therapists naive to the treatment of dissociative disorders believe that abreactions are new to the MPD patient. Patients know about abreactions before starting therapy, though they probably do not call them by name. Abreactive experiences are often described by the patient in the course of the evaluation process as follows:

"I don't know what happened, I just freaked out."

"I lost it."

"I went crazy."

Without the therapist's help the patient is perfectly capable of reconnecting a dysfunctional trauma-based perceptual structure to feelings. Cognitions are incidentals. But she has learned nothing from the abreactions other than to attempt to avoid them next time. Our role as therapists is to help the patient have a corrective abreactive experience. The therapist favors the reconnecting of affect to a non-trauma based (less trauma based) perceptual structure through the intermediary of nondistorted (less distorted) cognitive determinants. This cognitive restructuring involves

creating cognitive dissonance within the various alters through perceptual shifting and by slowly moving them to a perceptual/cognitive system tied to today's rather than yesterday's reality.

In summary, a three tiered interactional system may be operative with MPD patients in which cognitions represent both the entrance portal to the patient's reality as well as the intermediary— the go-between between affect and perceptual organization. Prior to the therapeutic abreactive work that involves connecting affect and a renegotiated perceptual organization, the therapist, through cognitive restructuring introduces elements of change in the once rigid assumptive world of the MPD patient. Therefore, before any productive and/or constructive changes can be proposed by therapists treating victims of childhood abuse who have developed MPD, it is essential for therapists to have an overview of their patients' cognitive reality and perceptual organization lest they find themselves in the position of abusers rather than helpers. ■

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