

**MOVEMENT
THERAPY
WITH MULTIPLE
PERSONALITY
DISORDER
PATIENTS**

Edith Z. Baum, MA., A.D.T.R.

Edith Z. Baum, M.A., A.D.T.R., is a movement therapist at the Dissociative Disorders Program at The Institute of Pennsylvania hospital.

For reprints write Edith Z. Baum, M.A., A.D.T.R., Activities Therapy Department, The Institute of Pennsylvania Hospital, 111 N. 49th Street, Philadelphia, PA 19139.

ABSTRACT

Group movement therapy with multiple personality disorder (.VMPD) patients can provide a useful healing experience, though the treatment of homogenous MPI) group can be a challenging endeavor. Four pervasive themes emerged in the movement sessions: establishing trust through kinesthetic empathy, negotiating social interaction, eliciting expressive movement and traumatic material, and integrating a more coherent sense of .self These themes were congruent with parallel developments in individual psychotherapy. The interdisciplinary collaboration of verbal and movement therapy works well together. Often work in one modality helps to negotiate impass-es in the other. The evocative power of movement and the therapeutic principles that flow from it, i.e., that one can move across the dimensions of behavior, affect, .sensation and knowledge (BASK), serves to reconnect the sequestered aspects of the traumatic past, encouraging integration.

INTRODUCTION

Movement (alternatively called dance) therapy is based on the assumptions that the body and the mind are inseparable, and that human body movement embodies and expresses inner psychic states.

There is so close an interrelation between the muscular sequence and the psychic attitude that not only does the psychic sequence connect up with the muscular states, but also ever' sequence of tensions and relaxations provokes a specific attitude. When there is a specific motor sequence it changes the inner situation and attitudes and even provokes a phantasy situation which fits the muscular sequence. (Shilder, 1950, p. 208).

Thus, not only do specific movements reflect certain inner psychic realities, but the movements may call forth images, moods, and memories. One can understand the way one feels from body movement as well as change the way one feels by changing movement behavior. To regain a sense of wholeness by experiencing the fundamental unity of body, mind, and spirit. is the ultimate goal of movement therapy

(Chaiklin, 1974; Levy, 1988).

Since the days of neolithic man, dance has served as an expression of tribal unity and strength, and has been used to mediate with external forces; e.g., fertility dances, war dances, etc. It has provided individuals with a means to express themselves and to communicate with others. The dances of the medicine man, priest or shaman belong to the oldest forms of healing, in which the release of tensions transformed physical and mental conflicts into healthier attitudes. At the dawn of civilization, dancing, religion, music, and medicine were inseparable (Meerlo, 1960).

In modern times, psychoanalysts and movement therapists encouraged the expression of inner turmoil for therapeutic purposes, and recognized the relationship between body expression and inner feelings. Freud himself acknowledged the connection between the body and the emotions in his oft quoted statement, "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If the lips are silent, he chatters with his finger tips, betrayal oozes out of him at every pore. And thus the task of making conscious the most hidden recesses of the mind is one which it is quite possible to accomplish" (Freud, 1905/1948, p 94). Wilhelm Reich (1944) believed that physiological behavior is fundamentally identical with psychic behavior. He postulates that "character armor" consists not only of psychological defenses, but also of muscular defenses, both of which serve to protect the individual against painful and threatening emotional experiences. While psychoanalysts and dance therapists have agreed about the interconnectedness of mind and body, psychoanalysts and psychoanalytically-oriented psychotherapists primarily encouraged verbal expression of the unconscious, while dance therapists used body movements as the vehicle for expression (Levy, 1988).

The early dance therapy pioneers were interested primarily in "spontaneity, authenticity of individual expression, awareness of the body, themes that stressed a whole range of feelings and relationships " (Bartenieff, 1975, p.246). Marion Chase, influenced by neo-Freudian and interpersonal theorists Harry Stack Sullivan and Freida Fromm-Reichman, used rhythm and synchrony to draw out patients from isolation and withdrawal. She perceived the role of the therapist as one who created opportunities for interrelatedness among patients as well as with the therapist. Expression, communication, and relatedness was the essence of her therapeutic work. This enabled her patients gradually to build a sense of self through interactions with others (Chaiklin H.,

1975). Whitehouse (1979), influenced by Jung, utilized movement as a key to reaching unconscious material. Her goal was to encourage individuals to let go of conscious control in order to move more freely and expressively.

According to Dyrud this release of muscle tension "may very well have been of particular value, because it occurred in a context of beginning dialog, re-establishing patterns of motility which could then logically extend from motor, to affective and cognitive sequences... in the dialog between patient and therapist" (1963, p 151). Current literature on child development suggests that the sequence of motor to affective to cognitive growth is seen in early-childhood development (Mahler & McDevitt, 1982). It is now recognized that the psychomotor development of the child provides the action which is subsequently internalized as thought and feeling. The movement therapy experience replicates this natural developmental process. Movement therapy can serve as a catalyst for the patient to relieve tension, allow expressive behavior, and create meaningful insights.

MOVEMENT THERAPY WITH MULTIPLE PERSONALITY DISORDER PATIENTS

Multiple personality disorder (MPD) nearly always occurs in the aftermath of severe and sustained child abuse (Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, et al., 1991; Schultz, Braun, & Kluff, 1989).

Because of the overwhelming trauma, NIPD patients dissociate much of their painful experience, gradually creating alter personalities and with them alternative "realities" more tolerable than the onerous one in which they live. From the perspective of the movement therapist, they may be understood to cut themselves off from their own feelings, armor their bodies, and separate their physical and psychological selves. The trauma creates feelings of powerlessness and betrayal, along with denial, shame, guilt, anger, rage, loss of control, and depression. Re-experiencing the trauma is equally overwhelming, and further characterized by intrusive feelings, denial, and emotional numbing (Horowitz, 1980).

MPD patients are often reluctant to move freely for fear of arousing material that will lead to loss of control. Instead, they keep a cautious watch against the triggering of material that eventually must be recalled. It is as if they intuitively appreciate both the evocative power of movement and the nature of Braun's BASK model of dissociation and the therapeutic principles that flow from them (Braun, 1988a, 1988b); i.e., that one can move across the dimensions of behavior, affect, sensation, and knowledge to reconnect the defensively sequestered aspects of their traumatic past.

Since MPD patients often cut themselves off from their traumatic experiences, verbal psychotherapy, the traditional treatment of choice, seems to progress more effectively in conjunction with non-verbal modalities (Kluft, 1984). In an oral presentation Baum, Kluft, and Reed (1984) described the therapeutic process and techniques involved in an interdisciplinary collaboration, such as the use of one modality to negotiate impasses in another. Art and movement were reported to facilitate the uncovering of material, to enhance

the integrative process, and to afford the patient an enhanced opportunity to participate in the milieu. By working with both verbal and movement therapies, individual and with groups, the growth of MPD patients' sense of self is encouraged by their learning to express feelings verbally and non-verbally, weaving together both physical and psychological aspects. The two work well together because while verbal therapy concentrates on the individual and the resolution of internal conflicts, a small therapy group is most useful; "multiple personality patients rarely have had the opportunity or the ability to understand the concepts of self and self in the world. Group therapy presents an opportunity for the MPD patient to participate in a sense of togetherness, with other humans in a social context" (Caul, Sachs, & Braun, 1986, p. 147).

In the context of movement therapy the painful memories which must surface and be worked through if healing is to take place may be triggered by the lyrics of a song, a movement, or the music, and then further explored in individual psychotherapy. It is not uncommon for the sensory motor aspects of a painful memory to be triggered in a movement session. Simply moving and focusing inwardly can bring to awareness a trauma that needs to be identified, expressed, and worked through. Thoughts and feelings first identified in a verbal session can be further explored in movement. Conversely, what is generated in a movement session can be elaborated upon and explored in verbal sessions. Such synergy facilitates increased connections across the BASK dimensions, encouraging aspects of integration. The reader will note that although the patients the author has treated have been involved in many other concurrent treatment modalities (such as art group therapy, music therapy, cognitive group therapy, verbal group therapy, occupational therapy, activities therapy, etc.) for the sake of exposition, only the synergy of movement and verbal therapy is discussed here.

ASPECTS OF GROUP MOVEMENT THERAPY WITH MPD PATIENTS

The author has conducted movement therapy group for MPD patients over a five-year period at The Institute of Pennsylvania Hospital. The treatment of homogeneous MPD groups can be a challenging endeavor, but, with adequate structure and judicious patient selection, it can provide a useful healing experience for this group of patients, who so often do poorly in groups with a diverse patient population (Caul, 1984; Caul, Sachs, & Braun, 1986; Coons & Bradley, 1985; Kluff, 1984).

The Institute's MPD movement therapy groups grew out of a need to decrease isolation and to encourage inter-relatedness and support among MPD patients, who were coming to The Institute in increasing numbers and often having difficulty in conventional movement group settings. Patients were referred by Richard Kluff, M.D., and the group was co-lead by Cathy McCoubrey, C.M.A., M.C.A.T., A.D.T.R., and the author. The first group consisted of five female members who met for one hour twice a week. All participants began as inpatients; two became outpatients. Attendance

was consistent with the exception of one member, who was hospitalized briefly in another facility. The group members were all in individual intensive psychotherapy. Over the course of treatment four themes emerged which were congruent with issues in the patients' individual work: establishing trust through kinesthetic empathy, negotiating social interaction, eliciting expressive movement and traumatic material, and integrating a more coherent sense of self.

Establishing Trust Through Kinesthetic Empathy

As a session begins, the group sits in a circle of chairs. The leaders check with each member, both verbally and non-verbally, to appreciate their mood and concerns. Then the group decides on the music to be played. After an initial warm-up, the group stands. One of the two leaders begins to move, picking up cues from one of the patients. At times, synchrony develops and members move rhythmically together. At other times, one patient might respond to inner stimuli, so the leader will pick up that person's movement to imitate and follow. The therapist's movement reflects what the patient is expressing, consciously or unconsciously. Replicating the patient's movement allows the therapist to share the patient's experience in the moment. The patient in turn experiences the therapist's acceptance. This empathic response from the therapist furthers the development of trust and the formation of a therapeutic relationship (Brumfield, 1981). With the deepening of trust, patients bring forth repressed images and feelings. When they can safely experience this material, their movements embody the personal truth of their histories.

Negotiating Social Interaction

Within the group setting, members learn how their movement affects others as well as how they react to others' movements. Patients can begin to identify dysfunctional styles of interaction and to practice alternate behaviors. For example, one patient was moving only minimally and avoiding eye contact, distancing herself from the group. During the processing, she was confronted by another member about this behavior. Much to her chagrin, she had been unaware of her behavior and her impact on the others. In the next session, she took a more active role, moving with more conviction and engaging actively with others. This more assertive behavior was supported by the therapist's replication of her new movement qualities. In this way the movement therapy provided opportunities to develop important social awareness and skills.

Members also learn to recognize the inner sources of their intense reactions to others. One patient came to a session wearing a long-sleeved shirt. Another patient guessed that her sleeves were covering self-inflicted wounds. This realization stimulated the observing patient to initiate punching movements. After just releasing the anger she first felt toward the injured patient, she was able to verbalize the intensity of her reaction and to recognize her own self-destructive impulses.

Group cohesiveness develops gradually as members come to appreciate the common bonds of their disorder. Trust

initially placed in the therapeutic relationship is extended among group members by moving together in a safe environment. When, in the middle of a session, one patient begins to respond to inner stimuli, or an alter suddenly initiates a new movement pattern, group members pick up the specific dynamic qualities. During processing, patients receive and often welcome feedback about how they moved and what affects were conveyed. The MPD patients can serve as auxiliary observing egos for each other even when their own fragmentation, amnesia, and distorted perceptions of self and others make it difficult for them to exercise this function for themselves on a reliable and consistent basis. Their experience in giving others such feedback often makes it possible for them to tolerate feedback both in movement therapy and in other settings.

Eliciting Expressive Movement and Traumatic Material

Authentic movement emerges when the mover follows an inner impulse generated by sensations or images. The mover learns to allow this unfolding, which is often enabled by closing the eyes. "The release maybe cathartic in nature... or it may be a quietly gentle experience of centering, of discovering a condition of harmony (congruence) between inner feelings and outer expression. Whether it is intense or gentle... authentic movement ultimately leads toward integration of the personality." (Smallwood, 1974, p. 26). An example of this occurred when a patient expressed the internal conflict of two personalities during a period of dissociation. The right side of the body physically struggled with the left side, as the right hand reached toward the throat and the left hand pulled it away. A self-destructive alter was struggling with an internal self helper.

Integrating a More Coherent Sense of Self

Movement therapy stimulates the sensory motor aspects of repressed memories (the sensation and behavior dimensions of BASK). The accompanying affects are re-experienced through the innate structure of movement in a safe interpersonal environment. This structure is determined by the organization of the body in space: i.e., the relationship of the body parts to the whole, the patterns of body tension, the initiation and flow of movement through the body, as well as the mover's inner attitude toward sensing and asserting herself with strength or lightness, intuiting and reflecting with suddenness or sustainment, attending with directness or multifocus, and expressing feelings with restraint or freedom (Lahan, 1960). The increasing awareness of one's body and moving self supports the mastery of overwhelming affect. The fluid nature of movement stimulates both fear of disorganization and loss of control as well as the potential for integration of feeling, thought, and action. Alters emerge, making themselves known by movement patterns that tell pieces of their story. The validation received from the group's replication of these patterns empowers the mover regardless of which alter is out. Associated images and memories combined with a sense of personal agency instruct the mover's perception of her autonomy.

As one patient remarked, "This group is helpful because

as I am able to re-experience the feelings that have been buried, I am able to begin to feel whole, rather than fractured into many pieces."

An example of an integration in a movement session occurred when Ella (a pseudonym) arrived and asked that "Memories" (Webber, 1974) be played. She was being discharged within a week and she was eager to master what she could before leaving. With eyes closed she slowly began to move, using the near reach kinesphere (i.e., the space near her) with gestural movements. Gradually this grew into full body movement with greater use of the space around her. The intensity of her movement built gradually as she stretched her arms up, fists clenched. Suddenly she pulled her body down bringing her arms in close to her body. Her head slowly curled down to her knees. Her whole body began to tremble. She began bending and writhing with great strain. Gradually the movement became rhythmic with more organized phrasing. When the song ended she recomposed herself and opened her eyes. "I'm sorry," she said, apparently referring to several previous sessions when she had lost control, dropping to the floor, kicking and screaming, while reliving earlier traumas. This time, however, her abreaction had remained under control. She stated that she was exhausted and needed to rest. The palms of her hands were wet. Though tired, she appeared relaxed and stated that she felt that an integration had taken place. This was later confirmed by her individual psychotherapist. While Ella was moving most of the others in the group attempted to replicate her intense expression. One patient stood immobilized, watching in awe. When Ella apologized, one member said that there was no need to apologize, that indeed her deeply felt reliving of traumatic material was impressive. Others nodded their heads in agreement.

CASE ILLUSTRATION

The case of Bea (a pseudonym) illustrates the themes discussed above over the course of her involvement with a long-term movement group for MPD patients.

Bea had a massive history of childhood sexual abuse, to which she had responded by elaborating dissociative defenses and the formation of alter personalities. Although she lived in personal anguish, she had functioned competently in a professional position for over a decade. When she arrived to her first movement session, her body appeared rigid, her movement patterns were restricted, and her use of the kinesphere was limited. There was little eye contact, with only an occasional glance at the therapist. She was frightened and insisted that the window in the door be covered so that no one would be able to look in. Unable to look at others or to tolerate others looking at her, she was withdrawn socially, hypervigilant, and rigidly armored to protect herself from others and her own repressed memories.

Creating a safe environment in which feelings could be expressed in an empathic nonjudgmental, caring environment was essential. To overcome her timidity, she needed and elicited continual support and reassurance. The initial movement therapy goal was to arouse responsiveness to

the kinesthetic stimulation of rhythm and movement. By replicating and developing the intent of the patient's movement initiative, use of space and body articulation, the therapist helped her to modulate the dynamic qualities of her actions. As she developed trust with the therapist and the group members, she began to move more freely, using a wider range of movement parameters, indicating growth in her coping mechanisms. At first, she would freeze and go into a trance-like state when traumatic material was triggered, or she would move tentatively, struggling to remain present. She shared feelings of isolation, difficulty with loss of time, and fear of how sharing her traumatic history might affect others. Gradually, she was able to take risks by improvising movements that triggered painful memories. While moving, Bea remembered a recent dream. Someone was watching and making negative comments. She was angry with me, associating me with the critical watcher. She came to realize that I reminded her of her mother, who had sold Bea's sexual favors to men in order to get money for drugs.

On another occasion Bea arrived wearing dark glasses, which she usually wore when she had a migraine headache. Not surprisingly, her body was rigid and her use of the kinesphere was limited. After the group warm-up, she removed her glasses and began stretching outwardly, using more of the space around her. The group was encouraged to join her in these slow movements as she stretched from side to side. Suddenly she quickened the pace. The movements were strong and directed outwardly, then just as suddenly she turned them on herself and began striking her body. Another personality had emerged, beating the body, and shouting in a deep masculine voice, "I'll kill you if you tell!" It appeared that she was recalling either a memory of an altercation with her abusive father or a fearful fantasy of one, in which one personality was an obedient masochistic daughter, another condemned her father angrily, and a third sadistically defended the father and was identified with him. In that movement sequence Bea was remembering important traumatic material for the first time. She went on to explore this material further in individual psychotherapy and art therapy (Baum, et al., 1984).

In another session, Bea arrived angry and silent. She had trouble staying with the group and was switching rapidly. Later in the session, Bea started to move with angry clenched fists which she released into light, quick fluid movements of her arms. Her eyes closed, perhaps indicating her fear of her anger. Then her fists clenched and flared open, tensing and releasing repetitively. With the therapist's cue, the group took hands around the circle and swayed together to create a safe container for these feelings. Bea shared her realization that although the material she was enacting had been uncovered in her verbal psychotherapy sessions, the feelings had, until now, remained isolated from the traumatic material. Through the movement her feelings had emerged and found expression.

Bea's progress from immobilization to a willingness to take risks, allowing authentic movement to emerge served as a role model for the other group members. As of this writing, she is nearing complete integration, has been out of the

hospital for nearly two years, and has begun volunteer work in preparation for return to full employment.

CONCLUSION

Group movement therapy with MPDs can be a useful modality in conjunction with verbal psychotherapy and other therapeutic interventions. Establishing trust is an ongoing issue with MPD patients, and is maintained through kinaesthetic empathy throughout the therapeutic process. Expressive movement elicits affect and memories related to earlier traumas, which can then be further explored in individual psychotherapy. Interdisciplinary collaboration enhances the integrative process by negotiating impasses between the physical and psychological aspects and working toward congruence between the two.

Negotiating social interaction is an important goal for patients who are isolative. Movement therapy provides an arena where members learn not only to move synchronously with others, but to explore ways to modulate their own dysfunctional styles of interaction.

Since MPD patients' bodies were often abused, they feel splintered and have formed many alters. By playing out these alters and their experiences in movement, they help bring shape and form to the various alters' self-expressions, thus facilitating integration of disowned aspects of themselves.

■

REFERENCES

- Bartenieff, I. (1975). Dance therapy; A new profession or a rediscovery of an ancient role of the (lance? In H. Chaiklin (Ed.) *Marian Chace: Her papers*, 246-255. Columbia, MD: American Dance Therapy Association. (Reprinted from *Dance Scope*, 1072-1973, Fall-Winter, 7, 6-18. American Dance Guild).
- Baum, E.Z., Kluft, R.P., & Reed, L. (1984). Interdisciplinary collaboration in the treatment of MPD: Art therapy, movement therapy and psychiatry (Abstract). In B.G. Braun (Ed.), *Dissociative disorders: Proceedings of the first international conference on multiple personality/dissociative states* (p. 91). Chicago: Rush University.
- Braun, B. G. (1988a). The BASK model of dissociation. *DISSOCIATION* 1(1), 4-23.
- Braun, B. G. (1988b). The BASK model of dissociation: Clinical applications. *DISSOCIATION*, 1(2), 16-23.
- Brumfield, R. (1981). *The development of a therapeutic personality for the movement/dance therapist*. Unpublished master's thesis, Fahnemann University, Philadelphia, PA.
- Caul, D. (1984). Group and video tape techniques for multiple personality disorder. *Psychiatric Annals*, 14, 50.
- Caul, D., Sachs, R.G., & Braun, B.G. (1986). *Group therapy in treatment of multiple personality disorder*. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 143-156). Washington, DC: American Psychiatric Press.
- Chaiklin, H. (Ed.) (1975). *Marian Chace: Her papers*. Columbia, MD: American Dance Therapy Association.
- Chaiklin, S. (1975). Dance therapy. In D.X. Freedman & J.E. Dyrud (Eds.), *American handbook of psychiatry* (2nd ed.) Vol. 5 Treatment (pp. 701-720). New York: Basic Books.
- Coons, J.E. & Chace, M. (1975). Movement and personality. In H. Chaiklin (Ed.), *Marian Chace: Her papers*. Columbia MD: American Dance Therapy Association. (Reprinted from Proceedings of Third Annual Conference (pp. 16-20), 1968, Madison WI: American Dance Therapy Association)
- Freud, S. (1948). Fragment of an analysis of a case of hysteria: The first dream. In E. Jones (Ed.) and A. Strachey & J. Strachey (Trans.). *The international psychoanalytical journal: Sigmund Freud: Collected papers*. (Vol. 3, pp. 78-113). London: Hogarth Press. (Original work published 1905)
- Horowitz, M.S., Wilner, N., Kaltreider, N., & Alvarez, W. (1980). Signs and symptoms of post-traumatic stress disorder. *Archives of General Psychiatry*, 37, 85-92.
- Kluft, R.P. (1984). An introduction to multiple personality disorder. *Psychiatric Annals*, 14, 19-24.
- Laban, R. (1971). *The mastery of movement* (3rd ed., rev.). Boston: Plays.
- Levy, F.J. (1988). *Dance/movement therapy: A healing art*. Reston, VA: The American Alliance for Health, Physical Education, Recreation, and Dance.
- Mahler, M.S. & McDevitt, J.B. (1982). Thoughts on the emergence of the sense of self with particular emphasis on the body self. *Journal of the American Psychoanalytic Assoc.*, 30, 827-848.
- Putnam, F. W., Guroff, J., Silberman, E. K., Barban, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293.
- Reich, W. (1944). *Character analysis*. New York: Orgone Institute Press.
- Ross, C. A., Miller, S. D., Bjornson, L., Reagor, P., Fraser, G. A., & Anderson, G. (1991). *Canadian journal of Psychiatry*, 36, 97-101.
- Schultz, R., Braun, B. G., & Kluft, R. P. (1989). Multiple personality disorder: Phenomenology of selected variables in comparison to major depression. *DISSOCIATION*, 2, 4-51.
- Schilder, P. (1950). *The image and appearance of the human body*. New York: International Universities Press.
- Smallwood, J. (1974). Philosophy and methods of individual work. In K.G. Mason (Ed.), *Dance therapy: Focus on dance VII* (pp. 24-26). Washington, DC: American Association for Health, Physical Education, and Recreation, a National Affiliate of the National Education Association.
- Webber, A.L. (Composer) & Streisand, B. (Singer). (1974). *Memories* (audiotape). New York: Columbia Broadcasting System.
- Whitehouse, M.S. (1979). C.G. Jung and dance therapy: Two major principles. In P.L. Bernstein (Ed.) *Eight theoretical approaches in dance/movement therapy*. (pp. 51-70). Dubuque, IA: Kendall/Hunt.

ACKNOWLEDGEMENTS

My appreciation to my daughter, Shelley Baum-Brunner, Ph.D., for her sensitive reading and many valuable suggestions with this article. My thanks to Catherine McCoubrey, C.M.A., M.C.A.T., A.D.T.R., my friend and co-leader over a two and one-half year period, for her support and assistance in bringing this paper to fruition.