

# CHILDREN COPING WITH TRAUMA: DIAGNOSIS OF "DISSOCIATION IDENTITY DISORDER"

Gary Peterson, M.D.

Gary Peterson, M.D., practices psychiatry at the Southeast Institute for Group and Family Therapy in Chapel Hill, North Carolina. He is affiliated with the Departments of Psychiatry and Psychology at The University of North Carolina in Chapel Hill, North Carolina.

A version of this paper was presented at the 37th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Chicago, Illinois, October 24-28, 1990.

For reprints write Gary Peterson, M.D., Southeast Institute for Group and Family Therapy, 103 Edwards Ridge, Chapel Hill, North Carolina 27514.

## ABSTRACT

*Dissociation is a common phenomenon in children. Under conditions of extreme stress, dissociation may be a veil to wall off traumatic memories. In extreme cases, the use of dissociation may result in the development of multiple personality disorder (MPD). In this paper, the literature of child MPD cases is summarized. Issues addressed include: developmental aspects of dissociation, child abuse leading to dissociation and multiple personality disorder, gender specific response to trauma, epidemiology, familial factors, checklists for childhood dissociation, and diagnostic criteria for a proposed diagnostic category called "Dissociation Identity Disorder" for the diagnosis of evolving children and adolescent MID.*

## INTRODUCTION

Dissociation as a mechanism of psychological defense against traumatic experiences has been relatively ignored within the child psychiatric community. Diagnosis and treatment of problems of dissociation in adulthood are only now beginning to come into acceptance by mental health service providers for the adult population. The dissociative disorder we call multiple personality disorder (NIPD) has taught us much about the treatment of dissociative disorders, and the time has come for us to recognize and treat problems of dissociation in youth.

During the past decade, great strides have been made in diagnosis and treatment of multiple personality disorder. Research has begun to help us better understand the unique features, etiology, physiology, natural course, and prognosis of those who suffer from this disorder (Coons, 1989; Putnam, 1989). There is a general consensus that MPD begins in childhood and a growing literature that it has varying forms at

different stages of development (Kluft, 1985a; Peterson, 1990a).

This paper will address the association between child abuse and dissociation, offer suggestions regarding early recognition of the dissociative problems in childhood, present a checklist for clinicians to increase the index of suspicion for dissociative disorders in youth, and suggest a set of diagnostic criteria that might be used to help in the evaluation of children for dissociative disorders.

In spite of the indications that MPD has a life course beginning in childhood (Braun & Sachs, 1985; Kluft, 1984c), child and adolescent mental health researchers and service providers have paid little attention to dissociation and the dissociative disorders. Issues of dissociation are not a focus of child psychiatric epidemiology (Beitchman, Kruidenier, Inglis, & Clegg, 1989; Brandenburg, Friedman, & Silver, 1990; Costello, 1989) or longitudinal studies (Cantwell & Baker, 1989; Esser, Schmidt, & Woerner, 1990), and current child psychiatry texts generally ignore dissociative phenomena (Garfinkel, Carlson, & Weller, 1990; Kaplan & Sadock, 1989; Mash & Barkley, 1989). Only this year has MPD been included for the first time in its major textbook on child psychiatry (Lewis, 1991).

Until recently (Peterson, 1990x), dissociation and dissociative disorders were not being considered by the child psychiatric working group for the American Psychiatric Association's DSM-IV Task Force (Shaffer et al., 1989). They are not being investigated in the field trials for *The World Health Organization's International Classification of Diseases*, 10th Edition (World Health Organization, 1987). If professionals working with children and adolescents were more aware of signs and symptoms of MPD (especially the unique features, etiologic factors, and natural course during developmental years), perhaps dissociative disorders would be recognized earlier, and appropriate therapies could be instituted.

## TAXONOMY OF DISSOCIATION

Whereas a few hundred cases of MPD had been reported prior to 1980 (Kluft, 1990), thousands of cases have been reported throughout the United States in the scientific literature and in national and regional conferences in the past decade. MPD was listed for the first time as a distinct entity in the *Diagnostic and Statistical Manual, Third Edition (DSM III)* (American Psychiatric Association, 1980). Official recognition and several other important factors summarized by Kluft (1987a) have catapulted MPD into a spotlight of inter-

est and controversy.

Prior to *DSM-III* in 1980, MPD was coded as hysterical neurosis, dissociative type, along with psychogenic amnesia, psychogenic fugue, and sleepwalking disorder. An appreciation of the differing signs and symptoms, likely predisposing factors and clinical courses of these four disorders led them to be separated in *DSM-III* (American Psychiatric Association, 1980). (*DSM-III* diagnostic criteria are listed in Table 1.)

*DSM-III-R* (American Psychiatric Association, 1987) modified the MPD criteria (see Table 1) to decrease the emphasis on dominance, complexity, and integration of personalities, in part because clinical experience had shown that the integrity and complexity of alternate personalities varies greatly. *DSM-III-R* criterion C proved overly restrictive and was set aside.

In considering the *DSM-III-R* revision, much attention was paid as to whether amnesia was to be included as a criterion. Because many patients were unaware of their amnesia and because it was believed that the inclusion of amnesia as a criterion would lead to under-diagnosis, amnesia was not included as a criterion for MPD (Kluft, Steinberg, & Spitzer, 1988). However, amnesia is a proposed criterion for MPD in *DSM-IV* (American Psychiatric Association, 1991).

#### DEVELOPMENTAL ASPECTS OF DISSOCIATION

Preschoolers spend much of their time in fantasy play and in activities of imagination. They experience their imag-

inary playmates as real and can be entranced for long periods of time in play activities. Their cognitive development is at a Piagetian pre-operational stage in which inanimate objects seem to be alive and to have intentions. An electric lamp *intends* to give you light and a furnace *means* to give you heat. Issues of cause and effect and conservation of matter have not been mastered (Kagan, 1984). There is a magical quality about preschool children's concept of death and a lack of awareness of the permanency of death (Speece & Brent, 1984; Weininger, 1979).

Dissociative phenomena are normal occurrences throughout development. Developmentally natural dissociative activities in tandem with primitive defence mechanisms may lead a child to block off painful memories using a dissociative process. As time goes on, this may become a preferred pattern of response to traumatic emotional experiences (Post, Rubinow, & Ballenger, 1984). This may have similarities to the *kindling* process that occurs in seizure disorders. Here repeated stimulation along selected nerve pathways leads to their becoming the preferential pathways of nerve impulse travel (Goddard, McIntyre, & Leech, 1969). Without a person's conscious volition, a pattern of protective dissociations may begin to develop, creating newly established and increasingly distinct parts of self, encapsulated in time, and memory segments that are unavailable to the rest of that person's consciousness.

Little is known about the ontogeny of dissociation in childhood. Putnam (1990, 1991) is currently undertaking a study to establish the incidence of dissociative phenomena throughout childhood using a dissociation inventory. Preliminary results suggest that dissociation is at its peak in the late preschool years, gradually declines during adolescence, and levels out in early adulthood. Just as in hypnosis (London & Cooper, 1969), there is no sex difference in the incidence of dissociative experiences in the normal population (Putnam, 1990).

#### CHILD ABUSE LEADING TO DISSOCIATION

Until recently, many reports of sexual abuse were attributed to childhood fantasies (Mason, 1984; Miller, 1984). Reports of child abuse in general and sexual abuse in particular have increased markedly over the past decade. Recently, however, there has been an increased awareness of the prevalence of child sexual abuse, and the serious consequences of such abuse are beginning to be described.

Studies of sexual abuse victims indicate a 4:1 or 5:1 female to male predominance (Dejong, Hervada, & Emmett, 1983; Mraick, Lynch, & Bentovim, 1983). Serafino (1979) studied child sexual abuse in four different locales, and found approximately one in 800 children reported having experienced sexual abuse in a one-year period.

Thirty-eight percent of the women in one retrospective incidence study reported at least one unwanted sexual experience involving actual physical contact with an adult prior to the age of eighteen (Russell, 1983). Russell conducted a random household sample of interviews with extensively trained female interviewers using a carefully designed

TABLE 1  
1) *DSM-III* and *DSM-III-R* Diagnostic Criteria for  
Multiple Personality Disorder

##### *DSM-III* Criteria

- A. The existence within the individual of two or more distinct personalities, each of which is dominant at any particular time.
- B. The personality that is dominant at any particular time determines the individual's behavior.

Each individual personality is complex and integrated with its own unique behavior patterns and social relationships.

##### *DSM-III-R* Criteria

- A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

standardized interview schedule. Twenty-eight percent of the women had had one unwanted sexual experience prior to the age of fourteen. Only 18% of these unwanted sexual experiences were ever reported to the police. Finkelhor (1980) found that 19% of female undergraduates reported having been sexually abused prior to age seventeen.

When compared to non-abused children, children who have been abused have a higher incidence of symptoms, such as anxiety and depression. Green (1988) examined abused, neglected, and control children who ranged in age from five to eleven. When he compared abused children to neglected and control children, the abused children reported to have displayed more self-destructive behaviors, including suicide attempts, suicidal gestures, and self-mutilation. These abused children were all described as having a sense of worthlessness, *badness*, and *self-hatred*.

Self-report measures have been used to evaluate emotional disturbance in children who have been abused. In comparing the incidence of depression in physically abused and non-abused psychiatric inpatients ages six to thirteen, Casen, Moser, Colbis, and Bill (1985) reported a greater degree of depression, lower self esteem, and a greater sense of hopelessness in the abused compared to the non-abused subjects. Externalizing disorders (including aggression, conduct problems, hyperactivity, and delinquency) have been reported to occur in children who have been abused (George & Maine, 1979; Hoffman-Plotkin & Twentvnan, 1984).

Evidence is beginning to grow in the association between childhood abuse and dissociation in both the general (Briere & Runtz, 1988) and clinical (Chu & Dill, 1990) populations. Briere and Runtz (1988) found that 15% of 278 university women had sexual contact with a significantly older person prior to age fifteen. When compared to non-abused women, these women reported higher levels of dissociation, somatization, anxiety, and depression. These four symptoms are common in MPD patients. The age of first abuse was not correlated specifically with the degree of dissociation, but these findings do support the relationship between sexual abuse and dissociative states. Chu and Dill (1990) found that female psychiatric inpatients who reported a history of having been sexually abused in childhood had higher levels of dissociative symptoms than those who did not report sexual abuse. In a preliminary study, Putnam (1990, 1991) reported that in abused children the degree of dissociation is greater than that in age, race, and SES matched controls; and that dissociation does not appreciably decrease over a one-year interval in abused children while it does decrease in non-abused children.

Until recently, dissociation and somatization generally have not been measured in the investigation of the clinical sequelae of child sexual abuse, making it difficult to examine the correlation of these potential outcomes of abuse. In their extensive review of the literature of sequelae of child sexual abuse, Browne and Finkelhor (1986) did not report any studies that measured dissociation and somatization. Briere and Runtz (1988) admonished the clinician to "consider the possibility of unresolved sexual abuse trauma, especially when client complaints include dissociation, somatization, and dys-

phoria." When the client has these complaints, the clinician is encouraged to consider the diagnosis of MPD as well.

## CHILD ABUSE ASSOCIATED WITH MULTIPLE PERSONALITY DISORDER

Two independently developed models of MPD are highly compatible with each other (Ross, 1989). A psychosocial model related to the development of MPD has been presented by Braun and Sachs (1985). In this model, three influences must be present for the development of MPD: (a) predisposing factors, (b) precipitating event, and (c) perpetuating phenomena. An individual may be biologically susceptible to dissociation and may be exposed to environments which are dynamically confusing or distressing. At some point during childhood, a precipitating crisis results in a dissociative episode. This crisis may be abusive in nature or it may be an accidental or other traumatizing event. In order for MPD to develop, there needs to be perpetuating phenomena, including environmental dynamics and perhaps family crises, which would reinforce the previous propensity towards dissociation, and ultimately result in the development of MPD.

Encompassing Braun and Sachs's model is a theory of MPD development promulgated by Kluft (1984c). In this formulation, a person who has the ability to dissociate encounters traumatic experiences. Inherent potentials for psychological separateness and environmental factors structure the use of dissociation as an adaptive mechanism. Finally, when significant others do not provide an opportunity to *metabolize* the trauma and/or the child is not protected from further traumata, MPD may develop.

An extraordinarily high incidence of a history of childhood abuse is reported by patients with MPD (often reported to be greater than 95%) (Coons, Bowman, & Milstein, 1988; Dell & Eisenhower, 1990; Putnam, Guroff, Silverman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989). Coons (1985) compared twenty MPD patients to twenty age and sex matched, non-dissociating, non-schizophrenic psychiatric patients. Abuse was much more prevalent in the MPD group. While one member of the control had suffered neglect and one had been sexually abused in childhood, 85% of the MPD patients had endured physical (75%) or sexual (55%) abuse.

In clinical settings, alternate personalities often can identify the time they came into existence and can associate a traumatic event to the time of their origination; alters often come into existence during a time of stress or crisis. They may identify themselves as having a protective role with the personality system (Putnam, 1989).

## GENDER SPECIFIC RESPONSE TO TRAUMA

Children who experience the trauma of separation, abuse, or neglect develop an array of symptoms. They tend to overreact to many situations and tolerate anxiety poorly. At rest, they may appear depressed, anxious, withdrawn, clinging, or passive (Green, 1980). Abused boys are more aggressive than are abused girls and they tend to identify with the aggressor (Carmen, Reiker, & Mills, 1984; Galdson, 1965; Hilberman,

1980).

Abused children tend to be hyperactive, impulsive, aggressive, destructive, self destructive, and accident prone (Green, 1978). Traumatized boys are more often hyperactive than are girls. While hyperactive children are at greater risk of becoming victims of abuse, there is growing evidence that abuse itself is a cause of hyperactivity (van der Kolk, 1984). Adult male psychiatric inpatients who were victims of child abuse and incest are more likely than comparable female inpatients to deal with their anger by becoming physically aggressive.

Male MPD patients appear to be more aggressive than are female MPD patients. In one study, males who had been diagnosed with MPD had a history of more antisocial behavior as compared to females (Ross & Norton, 1989). Over one-quarter of the males (28.6%) and 9.7% of the females had been convicted of crimes. Further, 28.6% of the male patients had been jailed, in comparison to 10.2% of the female patients. Males had spent somewhat less time in the mental health system prior to their first diagnosis of MPD, an average of 4.2 years compared to an average of 7.1 years for females. Male and female patients did not differ in age, marital status, number of children, or number of close relatives with suspected diagnosis of MPD. There was no significant difference in the proportion of male and female prostitutes. There was no significant difference between the males and females in the frequency of experiencing headaches or other somatic symptoms. The fact that so many males had a history of being jailed supports the theory that male MPD patients may be unavailable to the mental health system because they are involved in the justice system.

The antisocial qualities found in many male MPD adults also has been reported in MPD male adolescents. Kluft (1985) found that the symptoms in a sample of four males and eight females were quite different by gender. All four males had strong aggressive tendencies. Behaviors by the males included arson, attempted robbery, hugging, victimization, and destruction of property. Consequently, they all had problems with the legal system as well as the disciplinary system at school. Sometimes the male MPD adolescents would deny acts of which they were clearly guilty, and at other times they would verify the facts and even brag about them. The girls, on the other hand, exhibited other behaviors. Some were run-aways from incestuous or abusive families. Some were promiscuous; two had become pregnant; five had been raped, and three had heavy involvement in street drugs. Only one was flagrantly sociopathic. Somatic complaints were frequent, and these girls often requested and received medications for their symptoms. Suicidal behavior was common. Therefore, it appears that the antisocial nature of male MPD patients in adolescence may be carried through to criminal behavior and incarceration of male MPD patients during adulthood, making adolescent males with MPD less accessible to the mental health system than are females.

## EPIDEMIOLOGY OF MULTIPLE PERSONALITY DISORDER

Large epidemiological studies have not included the dissociative disorders as a focus of study (Beitchman, Kruidenier, Inglis, & Clegg, 1989; Brandenburg, Friedman, & Silver, 1990; Costello, 1989), limiting what is known about the incidence of these disorders. Estimates of frequency, male/female ratio, and age of onset are described here.

### Frequency

Because MPD has been considered to be a rare condition (Thigpen & Cleckley, 1984), it is seldom considered in the differential diagnosis of mental disorders. The medical aphorism "when you hear hoof beats, think of horses, not zebras" maybe at play in the under-diagnosis of MPD. Inquiries as to symptoms associated with MPD are not made by clinicians who are unfamiliar with or skeptical as to the existence of the disorder. If the clinician does not inquire as to the associated symptoms of MPD, it is unlikely that MPD will be diagnosed. Presenting symptoms of MPD patients typically contribute to the diagnosis of other, more common, mental disorders such as depression, anxiety, and somatization.

Several researchers have made educated guesses as to the incidence of MPD (Coons, 1984; Horevitz, 1983; Schafer, 1986). Ross (1989) suggests the point prevalence of MPD to be somewhere between 1 in 50 and 1 in 10,000 of the general population in urban North America, and his recent report substantiates the higher prevalence rate (Ross, 1991).

### Male/Female Ratio

Most patients identified as having MPD are female, with most reports indicating greater than four to one female to male ratio (Bliss, 1980, 1984; Bliss & Joppesen, 1985; Coons & Stern, 1986; Horevitz & Braun, 1984; Kluft, 1984c; Putnam, et al., 1986; Solomon, 1983; Stenr, 1984). Females were 90% of the MPD patients in a series of 236 cases (Ross, et al., 1989), 92% of 101 cases (Putnam, et al., 1986), and 100% of 14 cases (Bliss, 1980) in three studies.

The reason for the greater incidence (or recognition) of female MPD patients is unclear. Females have a greater incidence of having experienced sexual abuse (Dejong, Hervacla, & Emmett, 1983) and the trauma may have put them at risk for developing this disorder. Male MPD patients may be aggressive and behave differently than what is considered the Hassle presentation and therefore may be overlooked (Ross & Norton, 1989). As suggested above, males with MPD may be dealt with in the forensic system, making them unavailable to the mental health system.

### Age

There is strong consensus that MPD begins in childhood (Putnam, 1989). However, patients with MPD are usually first diagnosed in their late twenties and early thirties (Allison, 1978; bliss, 1980; Coons & Stern, 1986; Horevitz & Braun, 1984; Kluft, 1985c; Putnam, et al., 1986). Combining sexes, the mean age of a patient at the time of first diagnosis is over thirty years. Since the average time from initial

presentation to mental health services and the diagnosis of MPD is about seven years (Coons, et al., 1988; Putnam, et al., 1986; Ross, et al., 1989), these people were, on the average, over twenty-three years old when they first saw a therapist. Kluft (1985c) suggests that the most classical and florid symptoms consistent with MPD occur during their twenties and thirties, with less classical symptoms presenting prior to and after that time. This would help to explain why most people are diagnosed with MPD in their third and fourth decades of life.

## CHECKLISTS FOR CHILDHOOD DISSOCIATION

Because the appearance of MPD in youth may be unlike adult MPD, checklists for assessing the presence of MPD in youngsters have been suggested by several authors (Kluft, 1978, 1984b; Putnam, 1981; Fagan & McMahon, 1984). Three child MPD checklists have been published. The earliest was developed by Kluft (1978) and first appeared in print six years later (Kluft, 1984h). The Kluft checklist included items addressing amnestic experiences, trance-like states, fluctuations in behavior, developmental issues, appearance of lying, mood disorder symptoms, Schneiderian symptoms, poor response to intervention, family history for MPD and MPD-like symptoms.

In the second checklist, Putnam (1981) added hysterical symptoms/ sleep disturbance and a history of having been abused to the checklist of Kluft. The third checklist, and the first to actually be published, was that of Fagan and McMahon (1984), who developed a list which included many of the same areas that Putnam did, but added other behavior disordered symptoms, including truancy, injuring others, and several other conduct disorder symptoms.

A more comprehensive problem checklist, combining and consolidating these three checklists, could be instrumental in identifying younger people with MPD. Figure 1 is a proposed Child Dissociation Problem Checklist. Its categories can be combined into areas of major clinical importance by grouping the amnestic and trance-like experiences together (items 1-4), clustering the behavior fluctuation items (items 5-11), and grouping all the other symptoms which are frequently seen in other disorders as comprising a third section (items 12-45).

## CASE PRESENTATION

This case report illustrates how a child who has a possible dissociative process may come to the attention of the clinician and how the proposed consolidated checklist may accelerate the diagnostic process.

Cyndi (a pseudonym) was a twelve-year-old Caucasian girl referred from a distant city. Her mother was in treatment for MPD and had reported to her therapist that one of her child alternate personalities had approached Cyndi sexually. The purpose of the evaluation was to assess Cyndi's functioning and to make treatment recommendations. Cyndi's symptoms included lying, being sneaky, feeling anxious, and having severe headaches.

Mother observed many phenomena on the Fagan and McMahon (1984) behavior checklist. She described Cyndi staring at the air and not responding immediately to her name; showing sudden, major changes in personality and behavior; seeming to forget or becoming confused about very basic simple things; lying; not responding well to discipline; and having odd changes in her physical skill-sometimes drawing well and being creative, and sometimes not being able to think how to do things.

The teachers described her as "a very nervous acting child." She had a tendency to be upset and to cry easily. Sometimes she had difficulty concentrating on her assignments, but her teachers also described her as "a superb student who strives for excellence." She scored at or above average in achievement test scores.

Until the second divorce of her mother several years before, Cyndi had been raised in two successive nuclear families with her mother, father figure, and younger brother. Her mother was concerned that her stepfather might have abused her because he would sometimes hold Cyndi too close for Cyndi's comfort, and did so even when she did not want to be held. At age five, she had been treated by a psychologist for behavior problems. For three years prior to this evaluation, Cyndi had been seen by her school counselor.

On interview, Cyndi was verbal and cooperative. She admitted that for the past few years she had heard a voice in her head that helped her in times of distress. She denied having discussed her voice with anyone. This guiding voice was able to block out distressing memories. She had no memory of her mother's abusive behavior. She often would awaken from nightmares involving snakes.

Cyndi was referred to a therapist in her locality. On a two-month follow-up evaluation, Cyndi reported that she had not heard the voice since the previous session, and that her nightmares had almost gone away. On six months follow-up, Cyndi had been hospitalized for behavior symptoms once. Her therapist had not been able to substantiate an MPD diagnosis, though she was aware that Cyndi had dissociative symptoms. The Department of Social Services had become re-involved with her case because of the possibility of repeated abuse by her mother.

Cyndi's case illustrates some interesting and common aspects of dissociating youngsters. She had been molested by one and possibly both parents. She was amnestic for the abuse and other traumatic events. She had marked shifts in behavior. She heard voices from inside her head. Adults judged her to be a liar. Her mother had a dissociative disorder (MPD). She had been seen by two mental health service providers, neither having recognized the dissociative condition. On follow-up at six months, she was not diagnosable as having MPD even though her therapist was aware of her dissociative process.

## FAMILIAL FACTORS

That Cyndi's mother was an MPD patient leads to an interesting hypothesis that MPD is a familial (Braun, 1985) or cross-generational disorder (Kluft, 1984a). Several lac-

FIGURE 1  
CHILD DISSOCIATION PROBLEM CHECKLIST

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Date: \_\_\_\_\_

Please note which symptoms/items are present,  
using the following codes: + = present ? = don't know - = absent NA = not applicable

Rater: \_\_\_\_\_

1. \_\_\_\_\_ Amnesia
2. \_\_\_\_\_ Amnestic for abuse
3. \_\_\_\_\_ Forgets or seems confused about very basic, simple things
4. \_\_\_\_\_ Autohypnotic \_\_\_\_\_ or trance-like \_\_\_\_\_ behaviors.
5. \_\_\_\_\_ Dramatic changes in behavior \_\_\_\_\_ or language \_\_\_\_\_ (including accent \_\_\_\_\_ or voice tone \_\_\_\_\_ )
6. \_\_\_\_\_ Marked variation in social \_\_\_\_\_, cognitive \_\_\_\_\_, or physical ability \_\_\_\_\_
7. \_\_\_\_\_ Rapid regression \_\_\_\_\_ or variation in preferences for clothes \_\_\_\_\_, food \_\_\_\_\_, toys \_\_\_\_\_, games \_\_\_\_\_, other \_\_\_\_\_
8. \_\_\_\_\_ Sudden, recurrent shifts in friendship patterns
9. \_\_\_\_\_ Odd changes in physical skills
10. \_\_\_\_\_ Inconsistent school \_\_\_\_\_ or work \_\_\_\_\_ behavior
11. \_\_\_\_\_ Schoolwork goes from very good to bad
12. \_\_\_\_\_ Refers to self in third person
13. \_\_\_\_\_ Answers to - \_\_\_\_\_ or uses \_\_\_\_\_ another name to refer to self \_\_\_\_\_ or parts \_\_\_\_\_
14. \_\_\_\_\_ Current \_\_\_\_\_ or past \_\_\_\_\_ active imaginary companionship
15. \_\_\_\_\_ Imaginary companion is claimed to be "real"
16. \_\_\_\_\_ Attribution of behavior to imaginary playmate
17. \_\_\_\_\_ Has frequent disavowed observed behavior
18. \_\_\_\_\_ Disavowed polarized behavior (aggressive, "too good")
19. \_\_\_\_\_ Called a liar by others.
20. \_\_\_\_\_ When punished, claims innocence \_\_\_\_\_ or does not respond at all \_\_\_\_\_
21. \_\_\_\_\_ Frequent inappropriate sexual behaviors \_\_\_\_\_ or sexually precocious \_\_\_\_\_
22. \_\_\_\_\_ Hoarding food
23. \_\_\_\_\_ Stealing \_\_\_\_\_, destroy property \_\_\_\_\_, hurt animals \_\_\_\_\_, set fires \_\_\_\_\_
24. \_\_\_\_\_ Unprovoked explosive anger/violent behavior \_\_\_\_\_ Other antisocial behaviors \_\_\_\_\_
25. \_\_\_\_\_ Self-mutilation is present.
26. \_\_\_\_\_ Many physical complaints \_\_\_\_\_, illnesses \_\_\_\_\_, or injuries \_\_\_\_\_
27. \_\_\_\_\_ Rapidly fluctuating physical complaints
28. \_\_\_\_\_ Sudden blindness \_\_\_\_\_, seizure-like behavior \_\_\_\_\_, paralysis \_\_\_\_\_, loss of feeling \_\_\_\_\_ or pain sensation \_\_\_\_\_
29. \_\_\_\_\_ Intermittent depression
30. \_\_\_\_\_ Sleep disturbance \_\_\_\_\_ Sleep-walking: \_\_\_\_\_ Nightmares: \_\_\_\_\_ Night Terrors: \_\_\_\_\_
31. \_\_\_\_\_ Often lonely in pre- or grade school \_\_\_\_\_ Avoided/teased by peers: \_\_\_\_\_
32. \_\_\_\_\_ Numerous injuries \_\_\_\_\_, hurt taking chances \_\_\_\_\_, markedly careless \_\_\_\_\_
33. \_\_\_\_\_ Talks of dying \_\_\_\_\_, suicidal behavior \_\_\_\_\_
34. \_\_\_\_\_ Auditory hallucinations Inside head: \_\_\_\_\_ Outside head; \_\_\_\_\_ Visual hallucinations: \_\_\_\_\_
35. \_\_\_\_\_ Passive influence experiences: \_\_\_\_\_
36. \_\_\_\_\_ DSM-III Diagnoses: \_\_\_\_\_
37. \_\_\_\_\_ Attenuated expressions of MPD: \_\_\_\_\_
38. \_\_\_\_\_ First degree relative has MI'D Relationship: \_\_\_\_\_
39. \_\_\_\_\_ Other dissociators in family Relationship: \_\_\_\_\_
40. \_\_\_\_\_ Sustained repeated abuse Physical: \_\_\_\_\_ Sexual: \_\_\_\_\_ Age: \_\_\_\_\_
41. \_\_\_\_\_ Sent to principal/counselor because of behavior
42. \_\_\_\_\_ Truant for as much as five days
43. \_\_\_\_\_ Discipline has little \_\_\_\_\_ or no \_\_\_\_\_ effect
44. \_\_\_\_\_ Professionals do not seem to understand \_\_\_\_\_ or to be of much help \_\_\_\_\_
45. \_\_\_\_\_ Refractory

*Its categories can be combined into area of major clinical imprarue by grouping the amnestic and trance-like experiences together (items 1 - 4), clustering the behavior fluctuation items (items 5 - 11), and grouping all 'heather-symptoms which are frequ.ent() seen in other disorders as rom-prising a third section (items 12- f5),*

tors may support the likelihood of such occurrences:

- (a) Life for the offspring of an MPD parent may be experienced as chaotic as the child tries to accommodate to the ever changing roles and perception of the MPD parent. A dissociative adaptation by the child to the parent's switching personalities might be a useful survival mechanism. If the child switches, he or she can match the parent's temperament, perhaps decreasing the chance or intensity of abuse.
- (h) If the child is able to wall off the memories of abuse, he or she could more easily accept the support and affection of the parent when the parent is not being abusive.
- (c) The child has in the parent a role model for using dissociation to cope with stress.
- (d) There may be a genetic dimension to the tendency to dissociate.

The proportion of offspring of MPD patients who have MPD and other dissociative disorders is not known. One recent study shows a significant association between having a dissociative disorder in childhood and having a family history of MPD (Lord, *in press*). In another, twenty-three children of twenty adult MPD patients were compared to twenty-eight children of twenty adult general psychiatric patients (Coons, 1985). Two (9%) of the children of MPD patients were diagnosed as having a dissociative disorder. Only one (12%) of the eight female offspring was assessed as having a psychiatric disturbance while eight (53%) of the fifteen male offspring were so diagnosed. Eight (89%) of the nine disturbed children came from four (50%) of the eight families with children. These four families had striking marital dysfunction and severe MPD patient psychopathology. In the control group, only one child had a (non-dissociative) psychiatric disturbance. The high incidence (39%) of psychopathology in the children in the MPD families in this study indicates that children of MPD patients may be substantially at risk for psychological morbidity. Routine psychiatric evaluation of children living with MPD patients may be well advised.

## MULTIPLE PERSONALITY DISORDER IN YOUTH

Although MPD begins in childhood, only about 10% of MPD cases are diagnosed prior to age twenty (Kluft, 1985c). Part of the explanation is that the full and classic symptoms of MPD often are not presented until the late twenties and early thirties (Kluft, 1985c). Male and female adolescents with MPD may show symptoms more consistent with behavior disorder than overt MPD. However, the seed for MPD has been planted in childhood and the process of MPD is ongoing during adolescence in those persons who will not be

diagnosed as having MPD until they are in their twenties. These persons present as having anxiety, depression, somatization, and psychotic symptoms. Prior to the diagnosis of MPD, they are diagnosed as having a wide variety of disorders, including affective disorders, neurotic disorders, personality disorders, schizophrenia, and substance abuse disorders (Putnam et al., 1986). The average time from the patient's presenting to the mental health system and a clinician making the diagnosis of MPD is seven years (Coons, Bowman, & Milstein, 1988; Putnam et al., 1986; Ross, Norton, & Wozney, 1989). In addition to MPD, these patients have (on the average) been given two to four other diagnoses (Coons et al., 1988; Putnam et al., 1986; Ross et al., 1989).

Diagnosis of MPD in youth is more complex than it is for adults. In addition to the major adult categories, childhood MPD must be differentiated from attention-deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, and separation anxiety disorder (Dean, Giem, Guerro, & Leard, 1989). In a report of eleven adolescents with MPD (Dell & Eisenhower, 1990), the youngsters often met the criteria for mood disorders (64%), disruptive behavior disorders (55%), and post-traumatic stress disorder (45%). Two of the eleven met the criteria for borderline personality disorder. In order to diagnose an underlying dissociative disorder, inquiries as to the possibility of dissociation must be made by the diagnostician. The nature of these inquiries will be addressed in a later section.

Various theories about the etiology and natural course of MPD have resulted in the development of a number of approaches and descriptors to aid in the diagnosis of MPD in childhood. Creating these approaches has evolved from discussions of predictors of childhood MPD (Kluft, 1985b), the concept of "incipient multiple personality" (Fagan & McMahon, 1984), the notion of "precursors" of full-fledged multiple personality (Snowden, 1988), and the term "MPD in evolution" (Malenbaum & Russell, 1987). These approaches evolved because dissociating youngsters often appear to have a clinical presentation which is somewhat unlike the adult presentation of MPD, and may lack clear evidence of alternations of personality dominance or the presence of complex integrated personalities.

Wide variations in normal children's behavior help to complicate the identification of dissociative disorders in children. For example, preschool children spend a significant amount of their time in behaviors that mimic dissociated states. It is not at all uncommon for children to have imaginary friends or a sense of consciousness that might seem to them to be a voice inside their head (Harriman, 1937). Through the childhood and school-age years, the manifestations of MPD would not seem inconsistent with the range of behaviors that we expect of children who are learning to adjust to increasing numbers and types of situations. As children approach adolescence, a modulated variability of behavior is expected. Pressures in this direction are enhanced by the new challenges of adjusting to an evolving sexuality, an increasing independence from the family, and a preparation for becoming a productive contributor to society. A wide variety of mood and behavior states is expected from adolescents (Rutter,

Graham, Chadwick, & Yule, 1976); adolescents do regress to earlier stages of cognitive, emotional, and moral development when put under stress or into different environments (Blos, 1979).

These wide variations in child and adolescent behavior make the diagnosis of MPD more problematic with youth than with adults. In addition, many of the serious problems and symptoms of MPD which warrant investigation and intervention by the mental health system may not have appeared by the end of adolescence. Finally, the manifestations of MPD in childhood and adolescence appear to have somewhat less distinctive features relative to the indications that are present in adulthood, further complicating the diagnostic process (Kluft, 1985c).

### DISSOCIATION IDENTITY DISORDER

This section will discuss the evidence that childhood experiences set the stage for MPD and the possibility that we may be overlooking the dissociating youngster because we have not yet developed a framework within which to examine clinical dissociation in children. The current literature comprises twenty-six reasonably detailed case reports of children who have been described as having either MPD, precursors, or manifestations of MPD (Fagan & McMahan, 1984; Gainer, 1989; Kluft, 1984h; Malenbaum & Russell, 1987; Riley & Mead, 1988; Snowden, 1988; Waters, 1989; Weiss, Sutton, & Utecht, 1985). Elaborated personalities who control the person and are totally independent of other personalities are uncommon in these children. If these reports are taken collectively and the signs and symptoms they experience are totalled, the frequency of manifestation of these symptoms help define a syndrome which may be thought of as childhood manifestation of MPD. See Table 2.

Almost all of the children in these cases had amnesic periods and the majority of them had trance-like episodes. All of them had marked behavioral fluctuations. Other signs and symptoms which could be present in other disorders of childhood and adolescence varied from a low of 12% for having an imaginary companion, to 94% for being seen as lying, and 100% for having been depressed.

From the total of twenty-six cases plus the case of Cvndi just described, one may compile a set of diagnostic criteria which may serve as a reasonable basis for a dissociative disorder of childhood or dissociation identity disorder (Peterson, 1990a). Table 3 indicates suggested diagnostic criteria.

The imaginary companion as an item in the diagnostic criteria may be questioned. The role of the childhood imaginary companion in clinical child psychiatry is unclear. In one report, about one third of preschool and early school age children have imaginary companions, and carrying them into early adolescence is not considered problematic (Harriman, 1937). On the other hand, imaginary companions in childhood have been described as being associated with depersonalization during adolescence and adulthood (Myers, 1976).

No epidemiologic longitudinal assessments of the nature and course of the occurrence of imaginary companions has been reported. Since the imaginary companion has been

considered a transitional (Busch, Nagera, McKnight, & Pezzarossi, 1973) and splitting (Myers, 1976) phenomenon, maintenance and crystallization of these ego states may play a role in the development of MPD. Therefore, it may be useful to list having an imaginary companion as a diagnostic criterion as research in this area begins.

Using the criteria in Table 3 would encourage those assessing children and adolescents to consider dissociative phenomenon when evaluating new and continuing patients. If these criteria were met, then a psychotherapeutic intervention consistent with the approach to dissociative disorders, including MPD, could be implemented. The results of recognizing the dissociative phenomena and initiating the appropriate interventions in all likelihood would decrease the symptomatology, and, therefore, the psychic pain under which these children are suffering.

Using the dissociation construct and getting appropriate treatment for these youngsters may prevent development of full blown MPD in them during the adult years. Reports of treatment of children with MPD-like symptoms indicate that integration of alters is more rapid than for adults. In addition, these children appear to remain integrated if they are not exposed to additional severe trauma (Kluft, 1985b).

### CONCLUSION

The diagnosis of MPD has recently undergone a surge of clinical and research interest. However, many if not most clinicians still question the existence of the diagnosis. MPD is considered a rare condition in the mainstream of mental health service delivery and is not often in the differential diagnosis related to disorders of youth. Since thousands of MPD cases are being reported and it is widely held that MPD begins in childhood, and since the MPD diagnosis is usually made many years after a person enters the mental health system, we are compelled to examine the possibility that clinicians may be able to diagnose these individuals as having a dissociative disorder earlier in their symptom development.

In the process of examining those who have symptoms which may be consistent with MPD, the opportunity exists to open a framework of intervention which was previously unavailable using the traditional treatments for non-dissociative disorders. Reports of symptoms of multiple personality disorder in children promote the need to consider a dissociative disorder of childhood such as *dissociation identity disorder* for the following reasons:

- (1) Many youngsters who present with MPD-like symptoms do not have elaborated alters; to diagnose MPD in these situations may be clinically useful but technically incorrect.
- (2) Having a dissociative diagnosis in the Disorders Usually First Evident in Infancy, Childhood, or Adolescence section of the DSM-IV would alert diagnosticians and therapists to consider the dissociative spectrum in the differential diagnosis of mental disorders in youngsters.

TABLE 2  
Childhood Dissociation Identity Disorder Symptoms by Subject

	Age	Sex	Abuse	Amnesia	Trance	Behav Flux	Another Name	Imaginary Companion	Lying	Conduct Disorder	Sexual Preoccup.	Depres.	Disturb Sleep	Auditory Halluc.
<b>Fagan 1984</b>	6	F	+	+	+	+								
	6	F	+	+	+	+								
	8	F	?	+	+	+	+						+	
<b>Kluft 1985</b>	8	M	a	+	+	+	+	b	+			+	+	+
	9	NI		+	+	+	-	-	+			+	+	+
	8	M	+	+	+	+		+	-			+	-	+
	12	M	+	+	+	+	-		+	+		+	-	+
	9	NI	?	+	+	+	-	-	+	+		+	-	+
<b>Weiss 1985</b>	10	F	c	+	-	+			+	+	+			
<b>Malenbaum 1987</b>	11	NI				+		+	+	+		+	+	+
<b>Riley 1988</b>	3	F	+	+	+	+	+				+	?	+	
<b>Snowden 1988</b>					3/4*			2/4*			2/4*			3/4*
		F	+	+	+	+	-	+	+	+		?	+	+
	6	F	+	+		+			+				+	+
	9	M	+	+	+	+			+				+	
	10	M	+	+	+	+			+	+				+
<b>Waters 1989</b>	8-13		6/6	6/6	6/6	6/6	2/6		6/6			6/6	6/6	6/6
<b>Gainer 1989</b>	4	M	+	+	+	+	+	+		+			+	
	4	F	+	+	+	+					+		+	+
	10	M	+	+		+				+	+		+	
	9	M	+	+		+				+				
<b>Peterson</b>	11	F	+	+		+	-	+				+	+	+
<b>Totals</b>				25/25	21/24	26/26	8/18	5/12	17/18	9/13	8/12	13/13	18/22	17/19

a = Near drowning accident

h = Had imaginary companion from ages 4 to h

c = Abandoned by alcoholic mother

d = Numbe's user' are from tables of symptoms, sometimes not described by vignettes

- (3) The diagnosis of "dissociation identity disorder" would be less intimidating than the diagnosis of multiple personality disorder to the child, family, and community support system, should the diagnosis be made,
- (4) In appropriate cases, "dissociation identity disorder" would be used as an intermediate diagnosis until MPD was ruled in or out.
- (5) Using the "dissociation identity disorder" designation would direct the therapy into a dissociative paradigm as an umbrella concept, rather than having this dimension go unaddressed.

TABLE 3  
Suggested Diagnostic Criteria for  
"Dissociation Identity Disorder"

- (A) A disturbance of at least six months during which either one or two of the following are present:
  - (1) Recurrent amnesic periods of missing blocks of time
  - (2) Frequent trance-like states or appearing to be in a daze or in another world
- (B) Major fluctuations in behavior which may include dramatic changes in school or work performance and behavior or variations in apparent social, cognitive, or physical abilities.
- (C) At least three of the following:
  - (1) Refers to self in third person or uses another name to refer to self
  - (2) Has imaginary companion
    - Is seen as frequently lying
    - Has antisocial behaviors
    - Is sexually precocious
    - Has intermittent depression
    - Has frequent sleep problems
    - Has auditory hallucinations from inside the head.
- (I) Does not meet the criteria for Multiple Personality Disorder.

The lack of a distinct dissociative disorder identified with childhood and adolescence inhibits research and clinical recognition of the dissociative condition in youth. Those who are interested in the effective diagnosis and treatment of children and adolescents may encourage acceptance of this concept among those who are responsible for considering new diagnostic nomenclature.

Several groups have begun to develop measurements to examine the phenomenon of dissociation in youth. Now is the time for the mental health community to increase its recognition of dissociative disorders in youth. A framework of inquiry in the form of child behavior checklists is available to all clinicians. All diagnosticians must be open to the possibility of dissociation being a factor in their patients' behaviors. Especially in cases in which there is a history of abuse or a family history of MPD, inquiries about dissociation must be made. All evidence points to a natural history of MPD in which patients with MPD have developed dissociative symptoms in childhood; therefore, one must conclude that many children's dissociative symptoms are being overlooked. By including treatment for the dissociative symptoms, therapists can help dissociating youngsters experience the healing process which will lead to the resolution of their symptoms. ■

REFERENCES

Allison, R.R. (1978). A rational psychotherapy plan for multiplicity. *Svensk Tidsskrift Fur Hypnos*, 3-1, 9-10.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd Ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd Ed.-rev.). Washington, DC: Author.

American Psychiatric Association (1991). *DSM-IV options book: Work in progress*. Washington, DC: Author.

Beitchman, J.H., Kruidenier, B., Inglis, A., & Clegg, M. (1989). The children's self-report questionnaire: Factor score age trends and gender differences. *Journal of Child and Adolescent Psychiatry*, 28, 714-722.

Bliss, E.I. (1980). Multiple personalities: A report of fourteen cases with implications for schizophrenia and hysteria. *Archives of General Psychiatry*, 37, 1388-1397.

Bliss, E.I. (1984). A symptom profile of patients with multiple personalities, including MMPI results. *Journal of Nervous and Mental Disease*, 72, 197-202.

Bliss, E.I., & Jeppsen, E.A. (1985). Prevalence of multiple personality among inpatients and outpatients. *American Journal of Psychiatry*, 142, 250-251.

Blos, P. (1979). *The adolescent passage*. New York: International Universities Press.

- Brandenburg, N.A., Friedman, R.M., & Silver, S.E. (1990). The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 76-83.
- Braun, B.G. (1985). The transgenerational incidence of dissociation and multiple personality disorder: A preliminary report. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 127-150). Washington, DC: American Psychiatric Press.
- Braun, B.G., & Sachs, R.G. (1985). The development of multiple personality disorder: Predisposing, precipitating, and perpetuating factors. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press.
- Briere, J., & Runtz, M. (1988). Symptomatology association with childhood sexual victimization in a non-clinical adult sample. *Child Abuse and Neglect*, 12, 51-99.
- Browne, A., & Finkelhor, D. (1986). The impact of child sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66-77.
- Busch, F., Nagera, H., McKnight, J., & Pezzarossi, G. (1973). Primary transitional objects. *Journal of the American Academy of Child Psychiatry*, 12, 193-214.
- Cantwell, D.P., & Baker, L. (1989). Stability and natural history of DSM-III-R childhood diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 691-700.
- Carmen, E.L., Cicoker, P.P., & Mills, T. (1984). Victims of violence and psychiatric illness. *American Journal of Psychiatry*, 141, 378-379.
- Casclen, A.E., Moser, J., Colbis, D., & Bill, R. (1985). Depressive symptoms among physically abused and psychiatrically disturbed children. *Journal of Counseling and Clinical Psychology*, 94, 298-307.
- (Thu, J.A., & Dill, D.I. (1990). Dissociative symptoms in relation to childhood and physical and sexual abuse. *American Journal of Psychiatry*, 147, 887-892.
- Coons, P.M. (1984). The difference of diagnosis of multiple personality: A comprehensive review. *Psychiatric Clinics of North America*, 7, 51-67.
- Coons, P.M. (1985). Children of parents with multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 151-165). Washington, DC: American Psychiatric Press.
- Coons, P.M., Bowman, E.S., & Milstein, V. (1988). Multiple personality disorder: A clinical investigation of 5 cases. *Journal of Nervous and Mental Disease*, 176, 519-527.
- Coons, P.M., & Stern, A.L. (1986). Initial and follow-up psychological testing in a group of patients with multiple personality disorder. *Psychological Reports*, 58, 43-49.
- Costello, E.J. (1989). Developments in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 836-841.
- Dean, G.I., Giern, J., Guerro, J., & Leard, R.A. (1989). Comparison of incipient MPD and MPD predictors to disorders commonly diagnosed in children and adolescents [Summary]. *Proceedings of the sixth international conference on multiple personality/dissociative states*, p. 177.
- Dejong, A.R., Hervada, A.R., & Emmett, G.A. (1983). Epidemiological variations in childhood sexual abuse. *Child Abuse and Neglect*, 7, 155-162.
- Dell, P.F., & Eisenhower, J.W. (1990). Adolescent multiple personality disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 359-366.
- Esser, G., Schmidt, M.H., & Woerner, W. (1990). Epidemiology and course of psychiatric disorders in school-age children—results of a longitudinal study. *Journal of Child Psychology and Psychiatry*, 31, 243-263.
- Fagan, J., & McMahon, P.P. (1984). Incipient multiple personality in children. *Journal of Nervous and Mental Disease*, 172, 26-36.
- Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: The Free Press.
- Gainer, K. (1989). Monster as metaphor: Symbolic expressions in early childhood abuse victims [Summary]. *Proceedings of the sixth international conference on multiple personality/dissociative states*, p. 164.
- Galdson, R. (1965). Observations on children who have been physically abused and their parents. *American Journal of Psychiatry*, 122, 531-540.
- Garfinkel, B.D., Carlson, G.A., & Weller, E.B. (1990). *Psychiatric disorders in children and adolescents*. Philadelphia: Saunders.
- George, C., & Maine, M. (1979). Social interactions of young abused children: Approach, avoidance, and aggression. *Child Development*, 50, 306-318.
- Goddard, C.V., McIntyre, D.C., & Leach, C.K. (1969). A permanent change in brain functioning resulting from daily electrical stimulation. *Experimental Neurology*, 25, 295-330.
- Green, A. (1978). Self-destructive behavior in battered children. *American Journal of Psychiatry*, 135, 579-582.
- Green, A. (1980). *Child maltreatment*. New York: Aronson.
- Green, A. (1988). Child maltreatment and its victims: A comparison of physical and sexual abuse. *Psychiatric Clinics of North America*, 11, 591-610.
- Harriman, P.L. (1937). Some imaginary companions of older subjects. *American Journal of Orthopsychiatry*, 7, 3118-370.
- Hilberman, E. (1980). Wife beater's wife reconsidered. *American Journal of Psychiatry*, 137, 1336-1347.
- Hoffman-Plotkin, D., & Twentynran, C.T. (1984). A multinodal assessment of behavioral and cognitive deficits in abused and neglected preschoolers. *Child Development*, 55, 794-802.
- Horevitz, R.P. (1983). Hypnosis for multiple personality disorder: A framework for beginning. *American Journal of Clinical Hypnosis*, 26, 138-145.
- Horevitz, R.P., & Braun, B.G. (1984). Are multiple personalities borderline? An analysis of 33 cases. *Psychiatric Clinics of North America*, 7, 69-78.

- Kagan, J. (1984). *The nature of the child*. New York: Basic Books.
- Kaplan, I. I., and Sadock, B.J. (1989). *Comprehensive textbook of psychiatry/V* (5th Ed.). Baltimore: Williams & Wilkins.
- Kluft, R.P. (1978). Childhood multiple personality disorder, Unpublished data, in R.P. Kluft (1984). Multiple personality in childhood in *Psychiatric Clinics of North America*, 7, 121-134.
- Kluft, K.P. (1984a). An introduction to multiple personality disorder. *Psychiatric Annals*, 14, pp. 19, 22-24.
- Kluft, R.P. (1984b). Multiple personality in childhood in *Psychiatric Clinics of North America*, 7, 121-134.
- Muff, R.P. (1984c). Treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America*, 7, 9-29.
- Kluft, R.P. (1985a). *Childhood antecedents of multiple personality*. Washington, DC: American Psychiatric Press.
- Kluft, R.P. (1985b). Childhood multiple personality disorder: Predictors, clinical findings, and treatment results. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 167-196). Washington, DC: American Psychiatric Press.
- Kluft, R.P. (1985c). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 197-238). Washington, DC: American Psychiatric Press.
- Kluft, R.P. (1987). An update in multiple personality disorder. *Hospital and Community Psychiatry*, 38, 363-373.
- Kluft, R.P. (1990, January). *An historical perspective on multiple personality disorder*. Paper presented at the Ridgeview Center for Dissociative Disorders meeting Diagnosis and Treatment of Multiple Personality and Related Dissociative Disorders, Smyrna, Georgia.
- Kluft, K.Y. (1991). Multiple personality disorder. In A. Tasman and S.M. Goldfinger (Eds.), *American psychiatric press review of psychiatry*, Volume 10 (pp. 161-188). Washington, DC: American Psychiatric Press.
- Kluft, R.P., Steinberg, M., & Spitzer, R.I. (1988). DSM-III-R Revisions in the dissociative disorders: An exploration of their derivation and rationale. *DISSOCIATION*, 1(1), 39-46.
- Lewis, D.O. (1991). Multiple personality. In N.I. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 707-715). Baltimore: William and Wilkins.
- London, P., & Cooper, L.M. (1969). Norms of hypnotic susceptibility in children. *Developmental Psychology*, 1, 113-124.
- Lord, D.D. (in press). Dissociation, depression, and adjustment disorders: A retrospective study of presenting symptoms. *DISSOCIATION*.
- Malenbaum, R., & Russell, A.T. (1987). Multiple personality disorder in an eleven-year-old boy and his mother. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 436-439.
- Mash, F.J., & Barkley, R.A. (Eds.). (1989). *Treatment of childhood disorders*. New York: Guilford Press.
- Mason, J.M. (1984). *The assault on truth*. New York: Farrar, Straus, and Giroux.
- Miller, A. (1984). *Thou shalt not be aware: Society's betrayal of the child*. New York: Farrar, Straus, and Giroux.
- Mrazek, P., Lynch, M.A., & Bentovim, A. (1983). Sexual abuse of children in the United Kingdom. *Child Abuse and Neglect*, 7, 147-153.
- Myers, W.A. (1976). Imaginary companions, fantasy twins, mirror dreams and depersonalization. *Psychoanalytic Quarterly*, 45, 503-524.
- Peterson, G. (1990a). Diagnosis of childhood multiple personality disorder. *DISSOCIATION*, III, 3-9.
- Peterson, G. (1990b). Children coping with trauma: Diagnosis of "dissociation identity disorder." [Summary]. *Scientific proceedings of the annual meeting of the American academy of child and adolescent psychiatry*. Chicago, Illinois. Volume VI, p. 20.
- Post, R.M., Rubinow, D.R., & Ballenger, J.C. (1984). Conditioning, sensitization, and kindling: Implications for the course of affective illness. In R.M. Post & J.C. Ballenger (Eds.), *Neurobiology of mood disorders*. Baltimore: Williams & Wilkins.
- Putnam, F.W. (1981). Childhood MPD Proposal. Unpublished data in R.P. Kluft. (1984). Multiple personality in childhood. *Psychiatric Clinics of North America*, 7, 121-134.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.
- Putnam, F.W. (1990, June). *The dissociative disorders*. Paper presented at the Second Annual Eastern Regional Conference on Multiple Personality and Dissociation, Alexandria, Virginia.
- Putnam, F.W. (1991). Dissociative disorders in children and adolescents; Developmental perspective. *Psychiatric Clinics of North America*, 14, 519-532.
- Putnam, F.W., Guroff, J.J., Silverman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: A review of 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293.
- Riley, R.L., & Mead, J. (1988). The development of symptoms of multiple personality disorder in a child of three. *DISSOCIATION*, 1(4), 43-46.
- Ross, C.A. (1989). *Multiple personality disorder: Diagnosis, clinical features, and treatment*. New York: John Wiley & Sons.
- Ross, C.A. (1991). Epidemiology of multiple personality disorder and dissociation. *Psychiatric Clinics of North America*, 14, 503-518.
- Ross, C.A., & Norton, G.R. (1989). Differences between men and women with multiple personality disorder. *Hospital and Community Psychiatry*, 40, 186-188.
- Ross, C.A., Norton, G.R., & Wozney, K. (1989). Multiple personality disorder: An analysis of 236 cases. *Canadian Journal of Psychiatry*, 34, 413-418.
- Russell, D. (1983). The incidence and prevalence of interfamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect*, 7, 133-146.

Rutter, M., Graham, P., Chadwick, O.F.D., & Yule, W. (1976). Adolescent turmoil: Fact or fiction. *Journal of Child Psychology and Psychiatry*, 17, 35-56.

Serafino, E.P. (1979). Estimates of sexual offenses against children. *Child Welfare*, 38, 127-133.

Schafer, D.W. (1986). Recognizing multiple personality patients. *American Journal of Psychotherapy*, 40, 500-510.

Shaffer, D., Campbell, M., Cantwell, D., Bradley, S., Carlson, G., Cohen, D., Denckla, M., Frances, A., Garfinkel, B., Klein, R., Pincus, H., Spitzer, R.L., Volmar, F., & Widiger, T. (1989). Child and adolescent psychiatric disorders in *DSM-IV* Issues facing the work group. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 830-835.

Snowden, C. (1988). Where are all the childhood multiples? Identifying incipient multiple personality in children. [Summary]. *Proceedings of the Fifth International Conference on Multiple Personality/Dissociative States*, p. 36.

Solomon, R. (1983). The use of MMPI with multiple personality patients. *Psychological Reports*, 53, 1004-1016.

Speece, M.W., & Brent, S.B. (1984). Children's understanding of death: A review of three components of a death concept. *Child Development*, 55, 1671-1686.

Stern, C.R. (1984). The etiology of multiple personality. *Psychiatric Clinics (if North America)*, 7, 149-160.

Thigpen, (1.11.), & Cleckley, H.M. (1984). On the incidence of multiple personality disorder: A brief communication. *International Journal of Clinical and Experimental Hypnosis*, 32, 63-66.

Steinberg, M., Rounsaville, B., Sc Cicchetti, D.V. (1990). The structured clinical interview for *DSM-III-R* dissociative disorders: Preliminary report on a new diagnostic instrument. *American Journal of Psychiatry*, 147, 76-81.

**[861**

van der Kolk, B.A. (1984). *Post-traumatic stress disorder: Psychological and biological sequelae*. Washington, D.C.: American Psychiatric Press.

Waters, F.S. (1989). Non-hypnotic therapeutic techniques of multiple personality in children [Summary]. *Proceedings of the Sixth International Conference on Multiple Personality/Dissociative States*, p. 165.

Weininger, O. (1979). Young children's concepts of dying and dead. *Psychological Reports*, 44, 395-907.

Weiss, Ni., Sutton, P., & Utecht, A. (1985). Multiple personality in a ten-year-old girl. *Journal of the American Academy of Child and Adolescent Psychiatry*, 24, 495-501.

World Health Organization. (1987). *Tenth revision of the international classification of diseases Chapter V (F): Mental, behavioural, and developmental disorders. Revision I*. Geneva: Author.