DIAGNOSIS OF CHILDHOOD MULTIPLE PERSONALITY DISORDER

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ABSTRACT

From the recent surge of interest in multiple personality disorder (MPD), proliferation of clinical and scientific publications on the subject has emerged. MPD is understood to have its roots in childhood; however, little is known about this condition in youth. In many of the reports of childhood MPD the subjects fall short of meeting the full criteria as applied to adults.

In this paper checklists of signs and symptoms of MPD in youth are compared. These checklists are organized into symptom groups. Case vignettes of childhood MPD which recently have been reported by several authors are compared to these signs and symptoms. Most significantly, a set of diagnostic criteria which may be applied to children and adolescents with dissociation and major behavior disturbances and who may or may not have MPD have been proposed. The suggested designation for these diagnostic criteria is dissociation identity disorder.

INTRODUCTION

Over the past few decades, there has been a surge of interest in the clinical condition of multiple personality disorder (MPD) (Putnam, 1989, p.34; Ross, 1989, pp.44-55). Controversy continues about the existence of MPD (Kline, 1984) and whether it is an iatrogenic disorder (Spanos, Weekes, Menary, & Bertrand, 1986). Several large case studies of MPD have recently been published (Putnam, Guroff, Silverman, Barban, & Post, 1986; Ross, Norton & Wozney,1989; Coons, Bowman, & Milstein, 1988; Kluft, 1984b) adding to the understanding of this condition.

According to current thinking, the seeds for MPD are planted in childhood and may not become fully manifested until the third or even fourth decades of life (Kluft, 1985b). Braun and Sachs (1985) elaborated a paradigm for the understanding of MPD in which they describe the stage to be set when a child is predisposed to the disorder in having the capacity to dissociate and is exposed to a stressful environment in which abuse or some precipitating traumatic event causes overwhelming anxiety and results in the initial dissociative event. Further traumatic events perpetuate the propensity to dissociate, laying the groundwork for the eventual expression of MPD.

MPD DIAGNOSIS IN YOUTH

Even though the groundwork for severe dissociation is set in the preschool period, only a small proportion of these predisposed youngsters are being identified at an early age. The preponderance of people who have MPD are diagnosed after twenty years of age. Only 11 percent of the total number MPD diagnoses are made prior to age twenty. As indicated in Table 1, only 3 percent are diagnosed prior to age twelve (Kluft, 1985b).

Since successful treatment has been reported as simpler and more rapid in children with MPD than with adults with MPD (Kluft, 1985a, 1986), and since the average length of time from presentation to the mental health system and the diagnosis of MPD is about seven years (Putnam, 1986; Ross & Norton, 1989), the plight of many youngsters would be improved if the appropriate dissociative diagnosis were made at an earlier age.

Why are we not diagnosing earlier? Some would re-

TABLE 1
Age at Diagnosis of MPD
(From Kluft, 1985b)

AGE (YEARS)	PERCENT
< 12	3
12 - 19	8
20 - 39	65
40 - 49	15
50 - 59	6
≥ 60	3

spond that the condition of MPD is extremely rare, or does not exist at all (Dell, 1988a, 1988b), or at least does not exist developmentally. As with MPD in adulthood, youth with MPD may be misdiagnosed as any of several other mental disorders (Coons, 1984). Behaviors and symptoms may be misinterpreted as being other diagnoses, or other diagnoses may be present in addition to MPD (Fagan & McMahon, 1984). Other explanations may be that there are atypical presentations of MPD in that the child or adolescent personalities are not well-developed enough to elaborate complex personalities as their alters (Kluft, 1985a; Malenbaum & Russell, 1987). Some clinicians just do not ask the questions which will lead to the diagnosis – questions regarding missing blocks of time or other phenomena of dissociation, appearing to be in a trance, events which are not being discussed for fear of not being believed or for fear of punishment. And finally, there may be little apparent difference between the young alters and the age-appropriate behaviors of the child, making diagnosis harder (Kluft, 1985a, 1985b).

Other features in childhood MPD make the presentation of a child different from that of an adult. In fact some of the common manifestations of MPD in adulthood are not present in children. Persecutor personalities, inner self-helper personalities, and special-purpose fragments and systems of personalities are not being reported commonly in childhood MPD and may not exist in youngsters with MPD. Somatoform complaints and severe headaches are uncommon or vague in children (Kluft, 1985a).

In spite of the apparent differences in manifestations of MPD in childhood versus adulthood, in the *Diagnostic and Statistical Manual. (Third Edition-Revised)* (DSM-III-R) the diagnostic criteria for multiple personality disorder (300.14) are the same for patients of all ages, namely: "a) the existence within the person of two or more distinct personalities or personality states, and b) at least two of the personalities or personality states recurrently take full control of the person's behavior" (American Psychiatric Association, 1987, p.272). The DSM-III restrictive criterion C that "each individual personality is complex and integrated with its own behavior patterns and social relationships" (American Psychiatric Association 1980, p.259) has been set aside because of the varying degrees in which MPD patients were thought to have elaborated personalities. In considering the DSM-III-R revision, much attention was paid 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 underdiagnosis, this symptom was not included in the revised criteria (Kluft, Steinberg, & Spitzer, 1988).

Varied notions about children with MPD have resulted in the development of a number of approaches and descriptors to aid in the diagnosis. Among these approaches has been a discussion of predictors of childhood MPD (Kluft, 1985a), the concept of "incipient multiple personality" (Fagan and McMahon, 1984), the notion of "precursors" of full-fledged multiple personality (Snowden, 1988), and the term, "MPD in evolution" (Malenbaum and Russell, 1987) in children who meet the criteria, but do not have personality dominance or complex integrated personalities.

CHECKLISTS FOR CHILDHOOD MPD

Checklists for assessing the presence of MPD in youngsters have been suggested by several authors (Kluft, 1978; Putnam, 1981; Fagan & McMahon, 1984). From these checklists developed to characterize the nature of MPD in childhood the thoughts herein evolve. Of the three child MPD checklists, the earliest was developed by Kluft (1978) and first appeared in print six years later (Kluft, 1984a). The Kluft checklist included items addressing the amnestic experiences, trance-like states, fluctuations in behavior, developmental issues, appearance of lying, mood disorder symptoms, Schneiderian symptoms, poor response to non-specific intervention, family history for MPD, and the child's having MPD-like symptoms.

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

If these checklists are consolidated, the items may be grouped in the following manner: amnestic experiences, trance-like states, fluctuations in behavior, third person quality, developmental issues, conduct disordered behavior including appearance of lying and other (conduct disordered) behavior, hysterical symptoms/sleep disturbance, mood disorder symptoms, Schneiderian symptoms and symptoms supporting other diagnoses (Table 2). The terms "muted signs" of adult MPD and "attenuated expressions" of MPD are defined in a later publication (Kluft, 1985a). Other items from these checklists which do not represent signs or symptoms include: poor response to intervention, history of being abused, and family history of dissociation.

An item summary of the child MPD checklists compared to each other by category (Table 3) shows that all three had items in the areas of amnestic experience, fluctuations in behavior and developmental issues.

Table 4 illustrates a further combining of these categories, A) grouping the amnestic and trance-like experiences together, B) having the behavior fluctuation items stand alone, and C) grouping all the other symptoms which are frequently seen in other disorders as comprising a third section. The items in this "other group," can be designated as a "third person" quality, imaginary companion, seen as lying, conduct disordered, sexually precocious, intermittently depressed, having disturbed sleep, and having auditory hallucinations.

CASE REPORTS OF CHILDHOOD MPD

The current literature includes twenty-one case reports of children who have been described as having MPD or having precursors or manifestations of MPD (Fagan, 1984; Kluft, 1985; Malenbaum, 1987; Riley & Mead, 1988; Snowden, 1988; Waters, 1989; Weiss, 1985) in sufficient detail to be able to comment upon here. Elaborated personalities who con-

TABLE 2
Behavior Problem Checklists

Kluft (1978)

1. (md) Intermittent depression
2. (tr) Autohypnotic/trance-like behaviors
3. (be) Fluctuations in abilities, age-appropriateness, moods
4. (am) Amnesia
5. (sc) Hallucinated voices
6. (sc) Passive influence experiences, phenomena-suggesting
7. (de) Currently active imaginary companionship
8. (ly) Disavowed polarized behavior (aggressive, "too good")
9. (ly) Called a liar
10. (ly) Disavowed witnessed behavior
11. Muted signs of adult MPD
12. Attenuated expressions of MPD
13. (be) Inconsistent school behavior
14. Refractory to previous therapy
15. Dissociators in family
16. (dx) Other DSM-III diagnosis possible

Putnam (1981)

1. Sustained repeated abuse
2. (am) Amnestic for abuse
3. (hs) Self-mutilator
4. (sc) Auditory hallucinations
5. (be) Rapid regression/variation
6. (de) Talk to imaginary playmate older than 5 years
7. (be) Marked variation in ability
8. (am) Amnesia/denial
9. (de) Attribution to imaginary playmate or denial
10. (hs) Frequent sleepwalking
11. (hs) Hysterical symptoms
12. (hs) Rapidly fluctuative physical complaints
13. (th) Refer to self in third person

Fagan & McMahon (1984)

1. (tr) In a daze, trance, "Another World"
2. (th) Answers to or uses another name
3. (be) Big changes in personality and behavior
4. (am) Forgets or seems confused about very basic, simple things
5. (be) Odd changes in physical skills
6. (be) Schoolwork goes from very good to bad
7. (cd) Sent to principal/counselor because of behavior
8. Professionals do not seem to understand or to be much help
9. (ly) Lies; denies obvious misbehavior
10. Discipline has little or no effect
11. (ly) When punished, claims innocence or does not respond at all
12. (cd) Sealing, destroy property, hurt animals, set fires
13. (md) Numerous injuries, hurt taking chances, markedly careless
14. (cd) Injures others
15. (md) Talking of dying, suicidal behavior
16. (de) Age/person inappropriate sexual behavior
17. (cd) Truant for as much as five days
18. (md) Often lonely in pre- or grade school: avoided/teased by peers
19. (hs) Many physical complaints, illness, or injuries
20. (hs) Sleepwalking, night terrors, sudden blindness, seizure-like behavior, paralysis, loss of feeling or pain sensation

Comparison of child MPD behavior checklists currently available in the literature. Group codes: am=amnestic experiences, tr=trance-like experiences, be=behavior fluctuation, th="third person" quality, de=developmental issues, ly=seen as lying, cd=conduct disordered, hs=hysterical symptoms/sleep disturbance, md=mood disorder symptoms, sc=Schneiderian symptoms, and dx=supporting other diagnoses.

trol the person and are totally independent of other personalities are unusual in these children. If all of these reports are taken collectively and the signs and symptoms are totaled, the frequency of manifestation of these symptoms could serve as a basis for a syndrome which may be thought of as childhood manifestation of MPD. For the purposes of discussion, this childhood manifestation of MPD is designated as a dissociation identity disorder.

Almost all of the children in these case studies who could be designated as having a dissociation identity disorder had amnestic periods and the majority of them had trance-like episodes (Table 4). All of them had marked behavioral fluctuations. Other signs and symptoms which could be present in other disorders of childhood and adolescence varied from thirty percent for having an imaginary companion to ninety four percent for being seen as lying. Where depression is addressed, all had a positive history.

From the total of twenty-one cases, then, evolves a set of diagnostic criteria which may serve as a reasonable basis for a condition designated as dissociation identity disorder. Suggested criteria are as follows:

A) A disturbance of at least six months during which either one or two of the following are present:
   1) Recurrent amnestic periods or 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
   3) Is seen as frequently lying
   4) Has antisocial behaviors
   5) Is sexually precocious
   6) Has intermittent depression
   7) Has frequent sleep problems
   8) Has auditory hallucinations from inside the head.

D) Does not meet the criteria for multiple personality disorder.

Given that having an imaginary companion is considered a normal developmental phenomenon and may occur frequently in children, the criterion C-2, "has imaginary companion," may not be apropos. Perhaps an upper age for imaginary companion such as was used by Putnam (1981) in his checklist would be appropriate.

Using these criteria 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. In addition, using the dissociation construct and getting appropriate treatment for these youngsters may prevent development of full blown MPD in them during the adult years.

TABLE 3
Item Summary of child MPD Checklists

Category	Number of Items in Category		
	Kluft ('78)	Putnam ('81)	Fagan & McMahon ('84)
Amnestic Experiences	1	2	1
Trance-like States	1	0	1
Fluctuations in Behavior	2	2	3
Third Person Quality	0	1	1
Developmental Issues	1	2	1
Conduct Disorder(s) Behavior			
■ Appearance of Lying	3	0	2
■ Other Behavior	0	0	4
Hysterical Symptoms/ SleepDisturbance	0	4	2
Mood Disorder Symptoms	1	0	3
Schneiderian Symptoms	2	1	0
Supporting Other Diagnoses	1	0	0

REVISING THE DIAGNOSTIC NOMENCLATURE

The concept of having certain diagnostic categories in childhood and adolescence which are precursors to common adult disorders is not a new one for the DSM. Conduct disorder in youth is thought to be a precursor for antisocial personality disorder in adults. Avoidant disorder of childhood and adolescence may lead to avoidant personality disorder in adults. Identity disorder is thought to be a precursor to borderline personality disorder, and over-anxious disorder is thought not infrequently to lead to generalized anxiety disorder (APA, 1987, p.63, p.355).

If this new diagnostic category were accepted as a clinically useful entity, a great deal of effort would be required to have this category considered seriously by the Childhood and Adolescent Advisory Committee for the DSM-IV. Development of new diagnostic categories has

traditionally been a difficult task (APA, 1987, p.xxi). For the DSM-III-R Task Force to consider change of diagnostic criteria, several issues were studied, including:

1) Data from empirical studies.

2) Consensus that the revision would significantly increase the usefulness in making treatment and management decisions.

3) Presumed advantages of using the new criteria versus the presumed disadvantages to researchers who must switch to new criteria.

4) Consistency of the proposed revision with general approaches taken in the rest of the DSM classification hierarchy.

5) Interference with DSM and the ICD code compatibility.

6) Degree of operationalization of diagnostic reliability.

7) Unwarranted implication of an underlying theory about the mechanism of the disorder.

8) Premature consideration of the proposal which would more appropriately be within the scope of the next DSM (APA, 1987, p.xxi).

In order to *add a new* diagnosis, the Advisory Committee inquired whether:

1) The proposed category met the requirements of the DSM-III definition of mental disorder.

2) The research or clinical need for the category was compelling (APA, 1987, p.xxi).

Dissociation identity disorder does qualify as a mental disorder according to DSM-III-R (APA, 1987, p.401). Dissociation identity disorder as described would represent a behavioral and psychological syndrome or pattern and would be associated with distress, disability, and potential risk. This degree of dissociation would not be considered a usual response to stress and would be considered a manifestation of behavioral and psychological dysfunction in the person.

Compatibility with the clinical modification of the World Health Organization's International Classification of Diseases, 9th Edition (ICD-9-CM) (WHO, 1978) presents other problems. As indicated in Table 5, there are no current ICD-9-CM diagnostic categories under which the dissociation identity disorder could be classified. There are two section headings in ICD-9-CM under which dissociation identity disorder could logically be placed: a) 300.1 Hysteria and b) 313.8 Other or mixed emotional disturbances of childhood or adolescence. Of the diagnostic categories subsumed under the rubric of hysteria in ICD-9-CM, only unspecified hysteria has no corresponding diagnosis in DSM-III-R currently. In the category of other or mixed emotional disturbances of childhood or adolescence in the ICD-9-CM, all diagnoses are accounted for in DSM-III-R, with the exception of Academic Underachievement Disorder, for which there is no DSM-III-R corresponding diagnosis. Therefore, in order to establish a new diagnosis for childhood and adolescent manifestations of emerging MPD, either the current code for MPD would be used, or a modification of ICD-9-CM or a new ICD-10 diagnosis would be needed.

CONCLUSION

Current reports of multiple personality disorder in children promote the consideration for a diagnostic category of dissociation identity disorder for children and adolescents for the following reasons:

1) Many youngsters who present with MPD-like symp-

Table 4
Summary of Childhood "Dissociation Identity Disorder" Symptoms

	Fagan & McMahon 1984	Kluft 1985	Weiss 1985	Malenbaum 1987	Riley 1988	Snowden 1988	Waters 1989	Total
A								
Amnestic	3/3	5/5	1/1	?	1/1	4/4	6/6	20/20
Trance-like	3/3	5/5	0/1	0/1	1/1	3/4	6/6	18/21
B								
Behavior Fluctuates	3/3	5/5	1/1	1/1	1/1	4/4	6/6	21/21
C								
Another Name	2/2	1/5	1/1		1/1	0/1	2/6	7/15
Imaginary Companion		0/5		1/1		2/4		3/10
Seen as Lying	0/0	4/5	1/1	1/1		4/4	6/6	16/17
Conduct Disordered	0/3	2/2	1/1	1/1		3/3		7/7
Sexually Precocious	2/3		1/1		1/1	2/4		6/9
Intermittently Depressed		5/5	1/1	1/1	?			7/7
Disturbed Sleep	1/1	2/5	0/1	1/1	1/1	3/3	6/6	14/18
Auditory Hallucinations		5/5	0/1	1/1		3/4	6/6	15/17

toms 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 child and adolescent section of the manual alerts diagnosticians and therapists to consider the dissociative spectrum in differential diagnosis of mental disorders in youngsters.

3) The diagnosis of dissociation identity disorder would be less intimidating 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 interim 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.

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 wish to encourage acceptance of this concept among those who are responsible for considering new diagnostic nomenclature. ■

REFERENCES

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

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

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.

Coons, P. M. (1984). The differential of diagnosis of multiple personality: A comprehensive review. *Psychiatric Clinics of North America*, 7, 51-65.

Coons, P. M., Bowman, E. S., & Milstein, V. (1988). Multiple personality disorder: A clinical investigation of 50 cases. *Journal of Nervous and Mental Disease*, 176(9), 519-527.

Dell, P. F. (1988a). Not reasonable skepticism but extreme skepticism. *Journal of Nervous and Mental Disease*, 176, 537-538.

Dell, P. F. (1988b). Professional skepticism in multiple personality. *Journal of Nervous and Mental Disease*, 176 , 528-531.

Fagan, J., and McMahon, P.P. Incipient multiple personality in children. *Journal of Nervous and Mental Disease*, 172, 26-26, 1984.

Kline, M. V. (1984). Multiple personality: fact and artifacts in relation to hypnotherapy. *International Journal of Clinical and Experimental Hypnosis*, 32, 198-209.

Kluft, R. P. (1978). Childhood multiple personality disorder, Unpublished data, in Kluft, R.P. (1984). Multiple Personality in Childhood in *Psychiatric Clinics of North America*, 7, 121-134.

Kluft, R. P. (1984a). Multiple personality in childhood. *Psychiatric Clinics of North America*, 7, 121-134.

Kluft, R. P. (1984b). Treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America*, 7, 9-29.

Kluft, R. P. (1985a). Childhood multiple personality disorder:

TABLE 5
Relevant ICD-9-CM and Corresponding DSM-III-R Disorders

Other or Mixed Emotional Disturbances of Childhood or Adolescence (ICD-(-CM)		**Corresponding DSM-III-R Disorders**
313.81	Oppositional Disorder	313.81 Oppositional Defiant Disorder
313.82	Identity Disorder	313.82 Identity Disorder
313.83	Academic Underachievement Disorder	313.89 Reactive Attachment Disorder of Infancy or Early Childhood
313.89	Other	

Hysteria		**Corresponding DSM-III-R Disorders**
300.10	Hysteria, Unspecified	300.11 Conversion Disorder
300.11	Conversion Disorder	300.12 Psychogenic Amnesia
300.12	Psychogenic Amnesia	300.13 Psychogenic Fugue
300.13	Psychogenic Fugue	300.14 Multiple Personality Disorder
300.14	Multiple Personality Disorder	300.16 Factitious Illness with Psychological Symptoms
300.15	Dissociative Disorder or Reaction, Unspecified	300.19 Factitious Disorder NOS
300.15	Dissociative Disorder NOS	
300.16	Factitious Illness with Psychological Symptoms	
300.19	Other and Unspecified Factitious Illness	

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. (1985b). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood Antecedents of Multiple Personality* (pp.167-196). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986). Personality unification in multiple personality disorder (MPD). In B.G. Braun (Ed.). *The treatment of multiple personality disorder* (pp.79-105). Washington, DC: American Psychiatric Press.

Kluft, R.P., Steinberg, M., & Spitzer, R. L. (1988). DSM-III-R. Revisions in the dissociative disorders: An exploration of their derivation and rationale. *DISSOCIATION*, 1(1), 39-46.

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.

Putnam, F. (1981). Childhood MPD Proposal. Unpublished data in Kluft, R.P., (1984). Multiple Personality in Childhood in *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., 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(3), 43-46.

Ross, C. A. (1989). *Multiple personality disorder: diagnosis, clinical features , and treatment.* New York: John Wiley & Sons.

Ross, C.A., & Norton, G. R. (1989). Differences between men and women with multiple personality disorder. *Hospital and Community Psychiatry*, 40(2), 186-188.

Ross, C. A. Norton, G. R. & Wozney, K. (1989). Multiple personality disorder: An analysis of 236 cases. *Canadian Journal of Psychiatry*, 34(5), 413-418.

Snowden, C. (1988). Where are all the childhood multiples? Identifying/incipient multiple personality in children. [Summary]. In B.G. Braun (Ed.), *Proceedings of the Fifth International Conference on Multiple Personality/Dissociative States.* Rush: Chicago. P. 36.

Spanos, N. P., Weekes, J. R., Menary, E., & Bertrand, L. D. (1986). Hypnotic interview and age regression procedures in elicitation of multiple personality symptoms: A simulation study. *Psychiatry*, 49, 298-311.

Waters, F. S. (1989). Non-hypnotic therapeutic techniques of multiple personality in children [Summary]. In B.G. Braun (Ed.), *Proceedings of the Sixth International Conference on Multiple Personality/ Dissociative States.* Rush: Chicago. P. 165.

Weiss, M., Sutton P. and Utecht, A.J. (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. (1978). *Mental disorders: Glossary and guide to their classification in accordance with the ninth revision of the international classification of diseases.* Geneva: Author.