

CHILDHOOD  
MPD/DISSOCIATION  
IDENTITY DISORDER:  
APPLYING AND  
EXTENDING CURRENT  
DIAGNOSTIC  
CHECKLISTS

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### ABSTRACT

*Although relatively few articles and case reports of children diagnosed as multiple personality disorder/dissociation identity disorder have been published, there have been several pioneering attempts to construct or modify checklists of signs and symptoms of MPD in youth. This article applies the currently available checklists to six children who were evaluated by the author and offers additional possible indicators and factors which may function to mask or confuse the diagnostic picture.*

### INTRODUCTION

In recent years, interest in the phenomena of multiple personality disorders and related dissociative disorder and the frequency of their diagnoses among adult clinical populations has mushroomed. A review of recent psychological/psychiatric literature yielded references to over 250 articles relating to multiple personality disorder published between January 1983 and March 1991. Once thought to be a rare or very rare disorder, MPD is now estimated as afflicting approximately one percent of the general population (Ross, Joshi, & Currie, 1990). Vincent and Pickering (1988) quote Ross as estimating that approximately 5,000 cases of MPD were diagnosed in North America between 1977 and 1987. That figure has undoubtedly increased exponentially in the subsequent years as interest in and awareness of the phenomenon has grown and as diagnostic tools have been developed and refined. Important advances have included the development and publication of the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) and Dissociative Disorder Interview Schedule (DDIS) (Ross, Heber, Norton, & Anderson, 1988).

Consensus among leading researchers and retrospective reports from adult MPD patients strongly suggest that the seeds of multiple personality disorder are planted in childhood and, in the vast majority of cases, reflect an adaptive response to overwhelming trauma. Putnam, Guroff, Silberman, Barban, and Post's (1986) landmark review of 100 MPD patients suggests that 89 percent reported the first appearance of an alter personality prior to age twelve, with

a median age of onset of four years, and a mean age of onset of 5.98 years.

Despite strong evidence for the onset of this disorder prior to adulthood, my review of pertinent literature yielded a total of eleven articles and two book chapters pertaining to childhood MPD since 1979 (Fagan & McMahon, 1984; Kluft, 1984, 1985a, 1985b, 1986, 1990; Putnam, 1981; Weiss, Sutton, & Utecht, 1985; Riley & Mead, 1988; Malenbaum & Russell, 1987; Fine, 1988; Vincent & Pickering, 1988; Peterson, 1990). Peterson (1990) indicates that current literature reflects only 21 case reports of children described as having MPD or its precursors. Articles and case reports of adolescent MPD are also relatively sparse and consist of approximately six case studies (Alexander, 1956; Gruenwald, 1971; Horton & Miller, 1972; Fagan & McMahon, 1984; Bowman, Blix, & Coons, 1985), and reviews of 16 cases by Kluft (1985c), and 11 cases by Dell and Eisenhower (1990).

Several hypotheses have been forwarded to account for the extremely small number of reported cases prior to adulthood (Kluft, 1985b, 1985c; Peterson, 1990). These include the possibility that there are atypical presentations in childhood and adolescence, or that personalities are not well-developed enough to exhibit elaborate personalities, or that there is relatively little apparent difference between the young alters and the age-appropriate behaviors of the child, thus making detection and diagnosis more difficult.

There have been several pioneering efforts to create, modify, or extend the lists of clinical indicators, predictors, and signs that aid in the recognition of incipient and actual MPD in children (Kluft, 1984; Putnam, 1981; Fagan & McMahon, 1984). Table 1 displays the various checklists proposed to assist in identifying children with multiple personality disorder or its precursors. Content of the checklists designed to aid in the identification of MPD-like disorders in children suggests that many of the same factors which have made identification of adult MPDs difficult also exist with respect to children. Polysymptomatic presentations which may include hysterical symptoms, mood disorder symptoms, conduct disorder symptoms, and Schneiderian symptoms likely draw from mental health professionals primary diagnoses that are more familiar and less controversial.

Because symptom presentation in childhood and adolescence may be subtler and more attenuated than in adulthood, and because many of the children reported in the literature fall short of meeting the full criteria for MPD as applied to adults yet exhibit numerous MPD-like characteristics, Peterson (1990) has proposed the adoption of a diagnosis

of "dissociation identity disorder" (DID). Peterson (1990) summarized and consolidated previous symptom checklists and posed the following diagnostic criteria for "Dissociation Identity Disorder."

- A. A disturbance of at least six months during which one or two of the following are present:
  - 1. Recurrent amnesic 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 school or work performance and behavioral variations and 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 infrequently 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

In this article I will provide an additional source of validation for the currently available diagnostic or predictive checklists by applying Peterson's condensed version to six children between the ages of eight and twelve, whom I have interviewed within the past two years, and who appear to meet, at minimum, Peterson's criteria for "dissociation identity disorder." I will offer several additional clinical presentations, symptoms, and/or histories which appeared in this sample of children, but which have not been reported consistently in other case reports. Finally, I will report and discuss factors or symptoms which have not appeared previously in professional literature and suggest populations which might productively be screened or re-screened for presence of MPD-like disorders.

TABLE 1  
Behavior Problem Checklists

**Kluft (1978) reported in Kluft (1984)**

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

**Putnam (1981)**

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

**Fagan & McMahon (1984)**

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

## DESCRIPTION OF SAMPLE

All six of the children in this sample are Caucasian, and five of the six were interviewed in the context of a private outpatient clinical practice. The sixth child was seen on an inpatient unit as a consultation request from his attending physician. The children's ages ranged from eight years to twelve years old. Four of the children have been hospitalized for psychiatric treatment. The following case reports describe the children, their histories, and their symptoms. The children have been assigned pseudonyms to protect confidentiality.

## CASE REPORTS

### *Case One:*

Donna was initially referred to me for psychotherapy by the state foster care agency when she was eight years old. Donna was the youngest of several children. Her father, an alleged drug-user, died when Donna was approximately thirteen months old. The mother had numerous health problems and limitations secondary to polio. The family had come into contact with various welfare and law enforcement agencies for at least five years prior to my contact with Donna. Donna had her first foster care placement at or about age two. Several complaints of abuse and neglect were investigated dating back to Donna's fifth year. When she was seven years old, information began to emerge of possible sexual abuse. Ultimately, there were indications of sexual abuse by several adult males, primarily men described as her mother's boyfriends or friends. Relatively late in the contact, information began to emerge suggesting possible sexual abuse by the mother. The relationship between Donna and her mother was quite dysfunctional, with a considerable amount of parentification, role reversal, blaming, and confusing or binding communications emanating from the mother. Donna was removed from the mother's custody when she was approximately eight years old, and over the course of the next five years had probably a dozen or more foster or residential placements, the vast majority of which Donna disrupted by way of high levels of hyperactive, oppositional, aggressive, or sexually precocious behaviors.

I had intermittent contact with Donna over a nearly five-year period. As she was moved from placement to placement in varying geographic locations, her contacts were often disrupted or interrupted. Our contacts were never more than a few months in duration due to her numerous placements. Of all the children I have attempted to work with psychotherapeutically, Donna was probably the most difficult, most resistant, and most provocative. She evidenced an extremely high level of inattentive and disruptive behavior, was extraordinarily difficult to focus in therapy, and rather consistently was unable or unwilling to discuss abuse issues. The vast majority of our contacts occurred at a time in my career when I was almost wholly unaware and unfamiliar with dissociative disorders in children. Thus, for the first few years of contact with her, I consistently felt frustrated, perplexed, and discouraged. A relatively large number of the signs and symptoms in Peterson's diagnostic criteria had

exhibited themselves before I began to strongly suspect a Dissociation Identity Disorder. It was during a conference with her classroom teacher when the teacher began to describe different attitudes, behaviors, and academic skills depending upon where Donna chose to sit in the classroom on various days that I finally began to feel some certainty about her diagnosis.

Despite my continued pleas to the state foster care agency for a stable therapeutic placement, Donna continued to be moved from placement to placement as her disruptive behavior continued, and, in the case of precocious heterosexual and homosexual activities, increased. She was hospitalized in a psychiatric unit on one occasion for several weeks following runaway and aggressive behavior and received a diagnosis of "acute reaction of adolescence with mixed features of emotion and conduct." Previous psychiatric diagnoses included: attention deficit disorder with hyperactivity, conduct disorder, and "emotionally disturbed."

It is my understanding that Donna was returned to her mother's custody when she was thirteen or fourteen years old. She is thus seen as a therapeutic failure who appears at considerable risk for continued emotional and behavioral difficulties.

### *Case Two:*

Nate was an eight-year-old male whose mother referred him to me for a psychological evaluation. Nate's parents had been divorced since he was fifteen months old, and the mother, who has a multiple personality disorder, was forced to relinquish custody to the natural father when Nate was approximately two years old. During Nate's summer visitation with her, the mother began to observe behaviors and receive accounts which raised her concern that the natural father was physically and/or sexually abusing Nate. The mother hoped to verify or refute her suspicions and possibly block return of her son to the state in which the father resides. The mother provided anecdotal accounts, including witnessing the natural father striking Nate, the appearance of bruises on Nate's body, Nate's account of being kicked, hit with objects, locked out of the house, placed in trash dumpsters, and engaged in sexual activity (e.g., fellatio with his father or with other children). Anecdotal records also indicated a high level of precocious, unusual, and inappropriate sexual behaviors on Nate's part, to include fondling himself and masturbating in front of the window, exposing himself, grabbing the genitals of male visitors in the home, attempting to "French kiss" or "hunch" adult females such as his mother or aunt, verbally propositioning or using sexually explicit language in his conversation with other children, etc. Other behaviors included hyperactivity, high level of provocative, disruptive, and defiant behavior, fierce temper tantrums, suicidal and homicidal threats, begging for punishment or pain, engaging in odd stereotypic behaviors such as running around in circles while repeating words over and over. The mother indicated that on occasions he denied his actual name and claimed to be a person called "Joey."

Nate had been psychologically evaluated after his mother initially raised the issue of sexual abuse. According to the mother, the mental health professional concluded that Nate



was exhibiting an adjustment reaction with mixed emotional features. At some later point, he was also diagnosed as exhibiting an attention deficit disorder with hyperactivity and was prescribed Ritalin, which, the mother reported, did have something of a calming effect.

Formal psychological testing was inconclusive. He retracted and contradicted his claims of abuse at the hands of his father, and, during the testing, exhibited a high level of poorly focused activity, distractibility, and poor impulse control. The evaluation was completed at a time when I was just beginning to become aware of childhood precursors to multiple personality disorder, and when I had just begun to research the area. My written report thus reflected the confusing and contradictory test data, but concluded that Nate had probably been abused and likely suffered from some form of dissociative disorder. It was my recommendation that the child's return to his natural father be delayed, pending a thorough investigation which might include psychological evaluations of both the mother and father and a more extended opportunity to observe the child. However, local state protective services and the state attorney's office concluded that, while the child did appear to have some significant emotional and behavioral problems (probably precursors to childhood schizophrenia since the maternal grandfather was diagnosed a paranoid schizophrenic), there was no clear-cut evidence of abuse, and that the child could safely be returned to his father's custody in another state. I contacted a supervisor in the welfare department of the other state and was apparently unable to convince him that the child's welfare should be carefully monitored. The father has subsequently obstructed direct contact between Nate and his mother, and I have no follow-up information on this case.

#### *Case Three:*

Lyle was a nine-year-old male whose mother was seeing me for treatment of a multiple personality disorder. When she began to describe her son's emotional and behavioral adjustment, I suggested that Lyle be psychologically assessed. Lyle was described to me by his mother as being a hyperactive and emotionally immature young boy who had been previously diagnosed and treated for some type of seizure disorder. The mother was divorced from the child's father, and Lyle had been largely raised in the home of his maternal grandparents where the mother also resided for several years. The family unit was described as highly dysfunctional. The grandfather, a retired policeman with a felony conviction and a history of drug and alcohol abuse, was alleged to have sexually abused Lyle's mother throughout much of her childhood. The mother asserted that the grandparents controlled every aspect of Lyle's early life and seemed especially focused on his eating and elimination patterns. His mother believed that the grandfather had sexually abused Lyle. She was also aware of a very rejecting and possibly emotionally abusive alter personality of her own who did not relate well to Lyle. Lyle was described by his mother as having several animal alters who growled and made other animal noises, but did not speak. Their function apparently was to protect Lyle. Lyle talked openly about his animal personalities at times, but, at other times, totally denied their

existence or insisted that they were just "make believe."

During my contact with this family, Lyle was psychiatrically hospitalized on two occasions. He was initially hospitalized at the same time and in the same facility with his mother, who was concerned about her deteriorating relationship with her son and the possibility that their respective dissociative disorders were adding to the difficulties. The facility at which they were initially hospitalized was openly skeptical about their diagnoses, and Lyle was eventually discharged relatively unimproved with diagnostic impressions which included temporal lobe seizures, social deprivation secondary to intensely unstable home environment, delusional thinking, and dissociative thinking style. The mother subsequently brokered an admission to a specialized dissociative disorders unit in the Southwest where Lyle remained hospitalized for approximately four months before being released back to his mother's custody. Though this hospital made note of his trance-like states, his variable behavior, and apparent difficulties with identity, they seemed uncertain as to how he might be most properly and accurately diagnosed. One characteristic that was consistently noted during both hospitalizations was Lyle's tendency to alienate the other children and to set himself up in a victim's role. A series of neurological evaluations failed to reveal a clear-cut source for his apparent seizure disorder. Upon release from the hospital, Lyle and his mother planned to continue in psychotherapy. His mother was to continue being seen by me while Lyle was to be followed by an area psychologist who specializes in the treatment of children. However, the mother, who has been quite erratic and unstable in her contacts and behavioral patterns, moved to a different area of the state and has not kept in contact.

#### *Case Four:*

Amos was a twelve-year-old male whose mother was in treatment for multiple personality disorder. During the course of our contacts, the mother indicated to me that her son had been sexually abused by the natural father during early childhood and that he exhibited a number of behavioral and emotional problems. It was at my suggestion that he was seen for an assessment.

Psychosocial history revealed that the natural father left the home when the child was age two but had visitations until the child was six and a half. His mother learned that the father had been sexually abusing Amos over a three-year period. Amos was seen by several counselors in at least two community mental health centers before the age of ten and was referred to the school psychologist at age ten due to poor school behavior as well as difficulty in mastering academics. The psychological evaluation was suggestive of learning disabilities. At age eleven, he was placed in a children's home due to a combination of factors which included his behavioral and management difficulties, the mother's dangerously unstable dissociative disorder, and their financial difficulties.

At the time of my contact with this child, he continued to be a resident of the children's home and returned for weekend visits with his mother approximately twice monthly. Adjustment difficulties included "regression to four-year-

old behavior," encoyresis, aggressiveness and belligerence, poor school attendance, and school behavior problems. Since he has been at the children's home, there have been episodes in which he has become sexually aggressive or provocative towards other children, been accused of stealing and lying, and placed himself in the position where he is the object of scorn or aggressive behavior by other children. Individuals at the home have also noted times that he has spoken in a different voice, identified himself by another name, or claimed to have been influenced by an inner voice. Personnel at the children's home have been inclined to interpret this as attention-seeking or prevarication. While the mother has requested psychotherapy for her son, the home has primarily continued to deal with him through in-house counseling.

I met Amos for a diagnostic interview during an extended weekend visit with his mother. Like several of the preceding children, Amos was difficult to interview, exhibiting a high level of restless, inattentive, and poorly focused behaviors while tending to deny or minimize the nature and extent of his dissociative difficulties.

#### *Case Five:*

Pat was a well-developed twelve-year-old female when she was referred to me by a mental health counselor whom she was seeing following her discharge from a private psychiatric hospital. The counselor was skeptical concerning the possibility of a multiple personality disorder, a diagnostic impression which had been mentioned by the mother and by a psychologist who had seen Pat in the hospital.

This child's history included being treated for an apparent seizure disorder when she was ten months old. Her "staring sessions" continued even while she was taking Phenobarbital for approximately two years. The parents also indicated that she frequently had *deja vu* experiences. The parents separated and subsequently divorced before Pat's second birthday. The natural father, paternal grandmother, and paternal aunt are alleged to have serious alcohol problems. Pat showed a strong attachment to her father and paternal grandmother and has continued to have regular and frequent contact with them over the years. It is believed that her history included possible sexual molestation between the ages of three and five years by a teenage female babysitter. Pat began to exhibit very significant difficulties in the sixth grade when her grades began to drop, she began fabricating and telling fantastic stories, and she began writing bizarre passages and curse words in her diary. A runaway episode and claims of drinking and drug activity had precipitated her hospitalization. The mother began finding strange notes in her room, including notes relating to suicide ideation and attempts. The child also acknowledged hearing two voices in her head and experiencing blank spots in her memory. She also had a significant history of headaches and abdominal pain for which no physiological basis could be found.

With her counselor present, I met with Pat for a diagnostic interview. Pat consented to a hypnotic/ideomotor interview, and, utilizing finger signals, indicated the presence of at least five alter personalities, one of whom was willing to identify herself through automatic writing as being "Heather,

the Black Rose." Pat's presentation was thus one of the more classic and adult-like of the children that I have encountered. I saw Pat on a couple of subsequent occasions and have maintained intermittent contact with her mother.

Pat's father, who was legally responsible for health care expenses, and paternal grandmother, who was a very powerful and influential member of the extended family, were openly disparaging about her diagnosis, the need for any sort of treatment, and the motives of those who strongly recommended treatment. This factor, probably combined with Pat's need to deny the frightening aspects of her condition, led her to adamantly refuse therapy.

#### *Case Six:*

Edward was a twelve-year-old male undergoing his second psychiatric hospitalization when his attending psychiatrist requested a diagnostic consultation to address the issue of possible MPD. Interestingly, his fifteen-year-old sister was also an inpatient at the same facility. Both had been hospitalized on the basis of conduct problems. Edward's discharge diagnosis was conduct disorder. Concern was expressed about possible "psychotic-like thinking." Edward's second hospitalization was precipitated by rude and defiant behaviors, a runaway episode, and a fire-setting incident for which Edward alleged some suicidal intent. He stated that he had heard a voice telling him to "dig a hole, build a fire, jump in it, smell your flesh burning, and go live with the devil." A previous hospitalization had been precipitated by truancy and by fire-setting episodes centering around his threat to burn up his father and other threats relating to shooting his father with a BB gun. Also during the course of the first hospitalization, Edward mentioned to a psychologist having another part of himself, named "Ricky," who variously struggled or cooperated with him.

The parents' marriage was intact, and the hospital psychosocial history did not reveal a clear history of childhood traumata. Edward made reference to incidents from his childhood that his sister remembered but that he did not, and one such incident mentioned was having been whipped or beaten by his father. Upon examination, Edward was inclined to disclaim or minimize much of the above information, but he did agree to an administration of the Rorschach Inkblot Technique and spontaneously expressed interest in a hypnotic interview. The Rorschach revealed a bright, creative child whose cognitive world was dominated by thoughts of violent, morbid, or sexually-related material. The hypnotic/ideomotor interview suggested the presence of four alter personalities, including "Ricky" (described as the good child), an animal, a six-year-old girl named "Crystal," and a seven-year-old unnamed child. The latter briefly presented during the interview. At the time of the writing of this article, my contact with this child is limited to one diagnostic interview and several follow-up sessions, and it remains unclear as to whether I will be following the case when the children are transferred to a long-term residential treatment facility.

#### CHECKLIST APPLICATION

Table 2 presents the results of applying Peterson's



Symptom Checklist to the six cases described above and provides a comparison between the current sample and the twenty-one cases previously reported in the literature. As my contact with these children was, in many cases, quite limited, and since the majority of the children went to great lengths to conceal or deny their difficulties, anecdotal evidence from sources believed to be reliable were included with my direct findings and observations.

**DISCUSSION**

Results of applying Peterson's diagnostic criteria to the current sample of six children were quite consistent with Peterson's (1990) summary of previously reported cases. Six of the eleven descriptors applied to all of the children, while three descriptors applied to five of the six children, one applied to four of the six, and one descriptor applied to only three of the children.

On the basis of information available to date, it would appear that the most consistent or nearly universal symptoms for children with this disorder include recurrent amnesic periods or missing blocks of time, major fluctuations in behavior, disturbance in conduct, and intermittent depression. Nearly all of the children cited have also been seen as frequently lying. While it seems likely that using another name or having an imaginary companion may be highly predictive of this type of disorder, it is a symptom which does not occur invariably.

There were several items mentioned by other investigators as being linked to or predictive of childhood precursors of MPD which were not utilized in Peterson's proposed diagnostic criteria but appeared within the current sample. For example, three of the six children in the sample are offsprings of known dissociators, and one has a sibling with MPD. At least three, and possibly four, of the six can be seen as refractory to previous therapies. Two of the children reported some passive influence experiences. These three items had been suggested by Kluft in 1984.

Four of the six children were apparently victims of sustained repeated abuse, and there are at least some rumors of possible sexual abuse of one of the remaining children. The children appeared to be at least somewhat amnesic about

the abuse or at least highly reluctant to acknowledge it. These items are supportive of predictors suggested by Putnam in 1981.

Items from Fagan and McMahon's (1984) checklist which received some support include difficulties in socialization skills (i.e., being avoided or teased by peers), and the occurrence of seizure-like behaviors. In a couple of, and possibly three, cases, the children frequently appeared to maneuver themselves into positions where they were further victimized either by age peers or by caretakers. At least two seemed highly skilled at irritating, annoying, or otherwise provoking others. In this sample, three of the six had histories of seizures, and all three of the children were treated with anti-convulsive medication at least for brief periods. Only one of these three children was receiving anticonvulsive medication at the time of my contact, and he was subsequently withdrawn from medication after extensive neurological testing failed to substantiate true seizure disorder. The relationship between dissociative states and epilepsy has been explored by several authors (e.g., Devinsky, Putnam, Grafman, Bromfield, & Theodore, 1989; Drake, Pakalanis & Deni, 1988; Ross et al., 1989). Controversy still exists in regard to whether epilepsy may be a factor which precipitates or exacerbates development of dissociative disorders, although some recent findings suggest co-occurrence rather than an essential inter-relationship (Loewenstein & Putnam, 1988).

Two findings in the current investigation have not

TABLE 2  
Peterson's Item Checklist (1990)

|                          | Donna | Nate | Lyle | Amos | Pat | Edward | Sample Total | Previous Samples |
|--------------------------|-------|------|------|------|-----|--------|--------------|------------------|
| <b>A</b>                 |       |      |      |      |     |        |              |                  |
| Amnesic                  | x     | x    | x    | x    | x   | x      | 6/6          | 20/20            |
| Trance-like              | x     | x    | x    | x    | x   | x      | 6/6          | 18/21            |
| <b>B</b>                 |       |      |      |      |     |        |              |                  |
| Behavior fluctuations    | x     | x    | x    | x    | x   | x      | 6/6          | 21/21            |
| <b>C</b>                 |       |      |      |      |     |        |              |                  |
| Another name             | ?     | x    | x    | x    | x   | x      | 5/6          | 7/15             |
| Imaginary companion      | No    | x    | x    | ?    | x   | ?      | 3/6          | 3/10             |
| Seen as lying            | x     | x    | x    | x    | x   | x      | 6/6          | 16/17            |
| Conduct disordered       | x     | x    | x    | x    | x   | x      | 6/6          | 7/7              |
| Sexually precocious      | x     | x    | No   | x    | x   | x      | 5/6          | 6/9              |
| Intermittently depressed | x     | x    | x    | x    | x   | x      | 6/6          | 7/7              |
| Disturbed sleep          | x     | x    | x    | x    | ?   | x      | 5/6          | 14/18            |
| Auditory hallucinations  | ?     | ?    | x    | x    | x   | x      | 4/6          | 15/17            |

appeared to be clearly delineated in previous publications. In this sample, five out of the six children had been described by school or mental health personnel as hyperactive or as having an Attention Deficit Disorder. Four of the six had received Ritalin at some point in childhood. While there is some precedence for associating hyperactive behaviors with adult MPD patients (Bliss, 1984) and a reasonably large body of data associating hyperactivity and child abuse (Rogeness, Crawford & McNamara, 1989; Heffron, Martin, Welch & Perry, 1987; Gold, 1985; Felman & Nikitas, 1983; Penfold, 1982), it does not appear that ADD has previously been seen as a factor which might raise the index of suspicion for childhood MPD/DID.

Three of the six had been described by school or mental health personnel as exhibiting specific learning disabilities. Several of the previous investigators have alluded to fluctuations in school performances in various abilities. Thus, the current findings certainly reflect no new precedent except in possibly suggesting that dissociative disorders may be well represented among individuals who have been diagnosed as learning disabled.

There are perhaps now enough cases of childhood MPD or dissociation identity disorder to support the belief that there are some important and reasonably consistent differences between symptoms in adult MPD patients and the symptoms of childhood precursors. In this sample, for example, there is a relatively low frequency of multiple and rapidly changing somatic complaints. This is consistent with findings by Kluft (1985b). Only one of the children, a twelve-year-old female, reported a history of frequent severe headaches, a symptom which is seen with high frequency among adult female MPD patients. As a group, their presentation was less florid, less clearly delineated, and apparently less stable. Although the numbers of alter personalities revealed in this sample probably under-estimates the true number due to my very limited contact with the children, there seemed to be fewer alter personalities than are seen in adults.

An interesting additional finding in this sample relates to sex ratio. Putnam (1989) has estimated the sex ratio of diagnosed female to male adults with MPD as being possibly as high as five to one. In this particular sample, males outnumbered females four to two. This ratio is in line with the cumulative ratio of seven male to four female children whose cases were described in the literature by Kluft (1984, 1985b), Fagan and McMahon (1984), Weiss, Sutton, and Utecht (1985), and Malenbaum and Russell (1987). It appears that the significant higher prevalence of diagnosed MPD among female adults does not hold true during childhood, where the ratio may approach one to one or possibly reflect slightly more males than females. What happens developmentally or diagnostically between childhood and adulthood is an intriguing question that clearly warrants further research.

A final observation is the low frequency of clear therapeutic successes in this sample. Five of these children were, or became, inaccessible to me for treatment due to geographic placement or other placement decisions by courts, child welfare agencies, or parents. One, with the encouragement of a parent and grandparent, refused treatment. Four of the

six are unlikely to be receiving any sort of appropriate treatment at the present time. Only one is known to currently be in treatment. There appears to be a very high level of dysfunction with the families of these children, and lack of cooperation, support, and/or consistency among custodial agencies or individuals was a major obstacle in effecting appropriate treatment.

Kluft (1986) observed that therapists who have reported successful treatment of children with MPD "have been able to control their patients' life space so as to protect the children from further traumatization by others and from self-inflicted harm" (p. 93). Fagan and McMahon (1984), in referring to children with MPD, and Dell and Eisenhower (1990), who described a sample of eleven adolescents with MPD, emphasized the importance of benign and supportive families and/or caretakers in cases with positive outcomes. My experience with the six children described above appears to strongly support and reinforce these observations.

## CONCLUSION

The reliability and utility of the symptom checklist and diagnostic criteria Peterson constructed from the work of previous investigators of childhood MPD was clearly supported in this sample. Several of the items (amnesic experiences, behavioral variation, disturbance of conduct, and intermittent depression) appear to occur virtually invariably among the children who have been reported in the literature. Other items (e.g., using another name, having a current imaginary companion) appear less often or more equivocally and appear to be helpful, when present, in differentiating between MPD or dissociation identity disorder and other types of disorders. It continues to appear that children are less likely than adults to complain of recurrent headaches or other mysterious medical difficulties. It thus far appears as though self-mutilating behaviors are seen less frequently among children than in their adult counterparts.

Although there was some precedent in the works of previous investigators, the current sample revealed that a rather large proportion of these children had other dissociators in the family; frequently aggravated, provoked, or set themselves up for further victimization in their relationships with peers and others; and had in their medical histories treatment for apparent seizure disorders which were ultimately not well supported or well understood upon neurological examination. A high percentage of children in this sample had been diagnosed and treated for ADD or learning disabilities.

Intriguing questions raised by the present findings include the apparent changing sex ratio of MPD from childhood to adulthood and the possible relationship between "hyperactivity" in childhood MPD cases and manic-like affective disturbances in adulthood MPD cases.

Findings also imply that sub-populations of children being referred for evaluation of ADD and/or LD and children who are already being educated or treated under these designations may warrant greater scrutiny, especially if there is a known history of abuse or other overwhelming trauma. ■

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