

DISSOCIATIVE IDENTITY DISORDER IN CHILDHOOD: FIVE TURKISH CASES

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ABSTRACT

In this paper, the diagnostic processes, previous diagnoses, clinical symptomatology, life events, traumatic experiences, family histories, and treatment of five children (three girls and two boys between five and eleven years of age) with DID are presented. Clinical findings were headaches, aggressive behavior and outbursts, trance-like experiences, amnesias, inconsistent school performance, lying, sleep disturbances, and depressive symptoms. One of the patients had been treated previously under different diagnoses. The number of alter personalities ranged from two to eleven. One of the patients, a ten-year-old girl, had two distinct personality systems. All of the cases presented at least four Schneiderian first-rank symptoms except an eleven-year-old boy who had only one. All of the cases had amnesia between at least two alters during interviews initially, except for a five-year-old case who did not. A ten-year-old girl was treated successfully and her alter personalities integrated. The others discontinued the therapy.

INTRODUCTION

Dissociation is a psychophysiological process that occurs on a continuum ranging from minor normative dissociations such as daydreaming to psychiatric conditions such as dis-

sociative identity disorder (DID), a chronic and polysymptomatic condition formerly called multiple personality disorder (MPD) (Bernstein & Putnam, 1986; Putnam, 1991a). The essential feature of dissociative disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment (American Psychiatric Association, 1994).

In adults, increased levels of dissociation and the dissociative disorders are closely linked to abuse and trauma during childhood (Bliss, 1984; Branscomb, 1991; Chu & Dill, 1990; Coons, Bowman, & Milstein, 1988; Demitrack, Putnam, Brewerton, Brandt, & Gold, 1990; Putnam, 1985a; Ross & Miller, 1991; Yargic, Tutkun, & Sar, 1994). The same association has been shown also in child and adolescent cases (Bowman, Bliss, & Coons, 1985; Coons, 1994; Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Hornstein & Putnam, 1992; Hornstein & Tyson, 1991; Kluft, 1985a; Putnam, 1991b; Vincent & Pickering, 1988; Weiss, Sutton, & Utecht, 1985). However, the detection and documentation of dissociative disorders in children and adolescents have lagged behind those of adults (Putnam, 1991b).

The first published account of MPD in childhood was Despina's report of his patient "Estelle" 1840 (Ellenberger, 1970; Fine, 1988). This 11-year-old girl is also the first reported case of MPD whose treatment was successfully completed.

Fagan and McMahon (1984) described the syndrome of incipient MPD in four children. These authors described the process of diagnosis and treatment in detail and developed a predictor list based on their patients' symptoms and behaviors. Fagan and McMahon also found that family interventions and play therapy proved effective (Fagan & McMahon, 1984; McMahon & Fagan, 1989).

Kluft (1985a) reported five childhood cases of MPD. Kluft also derived a predictor list with 16 items. He emphasized the similarities and differences between child and adult cases of MPD, and summarized the difficulties of diagnosing MPD in children. Kluft reported that child cases of MPD were different from adult cases in the types and number of alter personalities, the alters' lesser narcissistic investment in separateness, greater ease and shorter lengths of treatment, and a diminished frequency of relapses. Kluft (1985a) has offered follow-ups on some of his cases, indicating that the poten-

tial for stability is good if retraumatization can be avoided, and that retraumatization can result in relapse.

Three more single cases were reported (Weiss et al., 1985; Malenbaum & Russel, 1987; Riley & Mead, 1988). Hornstein and Tyson (1991) described the diagnostic process and treatment outcome of eleven MPD and six DDNOS child cases in inpatient settings. They emphasized the role of hospitalization for adequate evaluation, establishing a therapeutic alliance, and providing a safe environment during therapy in some cases.

Since the mid-1980s, predictor lists for childhood dissociative disorders have been used (Elliott, 1982; Fagan & McMachon, 1984; Kluft, 1985a; Putnam, 1985b). Recently, Putnam, Helmers, and Trickert (1993) developed the Child Dissociation Scale (CDC) which has been shown as reliable and valid.

Child and adolescent patients with DID are frequently misdiagnosed because: 1) child cases with DID usually present with secondary signs and symptoms of the disorder. They frequently have signs of attention deficit and hyperactivity, conduct disorder, depression, anxiety, somatization, and post-traumatic stress disorder. Headache, nausea, vomiting, and fainting fits are the most frequent somatic complaints. Trance states and conversion symptoms, which are common in patients with DID, and rarer symptoms resembling psychomotor seizures may suggest epilepsy and other neurological disorders to the clinician. DID patients frequently report auditory and visual hallucinations and Schneider's first rank symptoms, so they may be misdiagnosed as schizophrenic; 2) because dissociation and dissociation-like phenomena are more common in normal children than in normal adults, dissociative symptoms of children may be erroneously interpreted as normal and ignored; 3) frequent intrafamilial abuse, a chaotic family environment, and frequent psychopathology in the members of the child's family may not only complicate the diagnosis but may also prevent follow-up; 4) children's being unaware of their circumstances and/or condition, their withholding data, and the different phenomenology of the childhood condition from the adult form also interfere with the condition's recognition; 5) above all, the most important reasons for misdiagnosis are clinicians' insufficient clinical experience with dissociative disorder and/or their disbelief about the legitimacy of DID as a diagnosis. (Fagan & McMachon, 1984; Kluft, 1985a, 1985b, 1987; Putnam, 1991; Hornstein & Tyson, 1991; Hornstein & Putnam, 1992; Putnam, 1993).

Child patients with DID are most frequently misdiagnosed as attention deficit and hyperactivity disorder, conversion and other somatoform disorders, conduct disorder, oppositional defiant disorder, schizophrenia, various forms of epilepsy, and affective disorders. However, the early diagnosis and treatment of DID is crucial. First of all, early recognition of trauma may prevent further traumatization. Also, DID can be more easily and quickly treated in children as compared

to adults. Correct diagnosis and appropriate treatment prevent misdiagnosis and inappropriate treatment (Fagan & McMachon, 1984; Kluft, 1985a, b; Putnam, 1991; Hornstein & Tyson, 1991; Hornstein & Putnam, 1992; Putnam, 1993). Treatment of adolescent patients with DID is less successful compared to adult and child patients (Yargic, Tutkun, Sar, & Zorogla, 1995). The detection of childhood DID cases is important for their reasons as well. First, most of the adult DID patients retrospectively attribute the origin of their symptoms to their early years. Child cases directly confirm this observation. Second, the confirmation of the actual abuse and trauma is more possible in children than in adults, which would also directly contribute to the illumination of the debate on false memory in DID patients. However, few child cases have been reported compared to the large case series that include adolescents and adults.

As a result of growing experience on the diagnosis and treatment of adolescent and adult patients with DID in Turkey in the last three years and sharing this experience with child psychiatrists, child cases with DID have been recognized here. As the literature on childhood DID is sparse our findings may illuminate this field a little further. We will describe here the identification of the first five cases in the Dissociative Disorders Program of the University Psychiatry Department in Istanbul. All names used throughout the case stories are pseudonyms.

CASE PRESENTATIONS

Hale

Hale, a 10.5-year-old female primary school student was brought by her mother with complaints of headache, nausea, irritability, and crying without any apparent cause, speaking to herself, laughing inappropriately, trance states in school, self-mutilation, delinquent behavior, using make up, and dressing inappropriately. She had had night terrors and visual hallucinations at night four years previously after the death of her uncle. Later on she became frightened during the day and she cried frequently. Her mother had consulted a "hoca" (quasi-religious type of folk healer) and he said that she was possessed by jinns (one type of non-human creature different from demons and angels in Turkish folklore). She got worse after this consultation. Headache, trance states, and other dissociative symptoms became established. Her EEG, cranial CT scan, and neurological examination did not reveal any organic cause.

During the first interview she said that she had been hearing voices in her head for a long time. One of these voices belonged to Cisem, a good girl, and the others were those of bad people of different ages and sexes. Bad voices threatened and forced her to do bad things and commented on her behavior. During subsequent interviews we contacted 11 alters, among whom were:

- 1) Cisem, an older girl, who wanted Hale to be

good and happy. She suggested that Hale not obey the orders of the other voices, nor listen to her mother and be religious. Cisem was also afraid of the other voices because they could punish her for helping Hale. Cisem's handwriting was different from Hale's. As a result, Hale had been beaten several times by her teacher for having someone else do her homework, and she had been forced to say that her mother did the homework.

- 2) Great Boss, an old man, was the leader of the bad group. He and his assistants could direct her feelings, speech, and behavior through a computer or they could put the computer in watching mode only. Thus, they could learn whatever she did. Hale felt herself like a robot when she was under control of the computer.
- 3) Erhan was one of the assistants of the Great Boss and he was very bad. He had stolen money from the teacher and Hale was punished for this. Hale claimed that she was innocent.

There were five more alter personalities under the control of the Great Boss and there was another system with two suicidal alters completely separate from the others.

Hale had been repeatedly punished by her family for being left-handed. She was beaten and her left arm had been tied behind her during her early school years. She was unsuccessful in the first class of the primary school because of high degree myopia, but neither her family nor her teacher believed her eye problem was genuine. They beat her until she was examined by an ophthalmologist one year later. Later, during the therapy, Hale said that Cisem had been raped and that she tried to help Cisem. She had been raped by a man named Erhan who then became one of the persecutor alters. The rape experience was repeated during flashbacks. Hale definitely denied that it was she who had been raped and insisted that the separateness of Cisem was genuine.

All alters integrated in 26 sessions and all previous symptoms disappeared.

Mine

Mine, a nine-year-old girl in the fourth year of a primary school was brought to the emergency psychiatric unit of our child psychiatry clinic while her mother was hospitalized. Her father and brother complained that her behavior changed abruptly when her father came home. She became moody and aggressive. She cried frequently and acted as if she were seeing figures. She seemed to fear them although she spoke to them continuously. Once she rushed out of the house and begged two policemen to help and protect her

from the two men following her. In fact these two men were her father and brother, whom she did not recognize as such. She spent the night at the police station. The next morning, when she returned to her normal state, she did not remember anything of what had happened the day before. This was then diagnosed as a dissociative episode. A follow-up was not possible at that time.

However, when the mother, who herself was under psychiatric treatment with diagnosis of a DID told her psychiatrist about her daughter, we were able to contact the girl again, one year after her first admission. The mother said her daughter was often absent-minded, that she spoke to herself, was irritable, and complained of headache and nausea during these periods and her behavior was inconsistent. The girl had told her mother that she had a girlfriend within her whom she could see and play with. The girl held her father and the boys at school at a distance. Her strange behavior, irritability, and absent-mindedness caused problems at school, too. She had to miss classes frequently because of her headaches. Her IQ was 117 as determined by the Cattel 2A intelligence test.

Mine said that she heard voices in her head. She was on good terms with the owner of a voice who was a year younger than herself and had done things autonomously though Mine, the host personality, did not know how she had done them. This alter personality fantasized that her friend had done something, but later she recognized that she had done it. At the third interview this alter personality took full control during a puzzle game and introduced herself as Ayse, saying she had been with Mine for three years. She was on good terms with her and was fond of her. She wrote her name on a sheet of paper. When she was asked where Mine was she answered that she did not know and continued to play silently. When Mine took full control a little later, she looked at the puzzle half completed by Ayse but was not aware of how much time had passed or of what Ayse had done. She admitted that there had been several similar incidents, but could not remember the details. In the next interview Ayse said that neither she nor Mine liked Mine's father. Later, another personality of the persecutor type and of the opposite sex was identified.

Mine's father was an unemployed chronic alcoholic and a gambler who took money from his wife by force. He beat his wife and the children. The mother had absences due to long hospitalizations almost every year. After five interviews with the patient, her mother decompensated. Mine's psychotherapy was interrupted. It started again following her mother's three-month hospitalization, and is still going on.

Mehmet

Mehmet, an 11-year-old secondary school boy had been the best student in his class. His family complained that his behavior changed. He could no longer read or write and spoke like an infant. He could not pronounce the letter "R."

He did not know his name nor how old he was. The only thing he could remember was his parents. He behaved like a small introverted child and played with toys inappropriate for his age. He enjoyed Kung-Fu movies. He had no sense of time.

He was followed, once weekly, on an outpatient basis for two months. He was brought to the fourth session in his pre-morbid personality. He did not remember his therapist nor the previous sessions. He was a bright and friendly boy; his behavior and speech were very mature for his age; he was interested in science. He was totally amnesic for his "childish periods." His IQ was 116 on the Cattell 2A intelligence test. A Rorschach testing revealed findings which were interpreted as indicating aggressivity, identification problems, avoidance of contact with the outside world, and problems with authority figures.

His parents informed us that the recurrent personality switches had started three months previously. Each personality state lasted for three to four days recurrently and he could not remember anything about the periods when the other personality was in control. He occasionally had contractions in his arms, lasting ten to thirty minutes.

Mehmet had been hospitalized four times in different hospitals, including two university clinics. A medical work-up, (including neurological examination, cranial CT scan, and many EEGs) was normal. His contractions were observed in hospital and diagnosed as conversion disorder. He also had other conversion symptoms such as short periods of astasia and paresthesia. Anti-psychotic, anti-depressant, minor tranquilizers, and anti-epileptic medications had not helped him. Instead, these medications precipitated violent behavior.

These two alters had their own pattern of perceiving, relating to, and thinking about the environment and self. They described dramatic black-outs. During follow-up two more personality states were observed. On the first, he lost his abilities to walk and speak. His voice was that of a baby's. In the second, he behaved strangely, cried "I am crazy, I am crazy," and recognized nobody.

He revealed no psychological or physical trauma. His older sister also claimed that there had been no type of intrafamilial abuse or neglect.

None of the personality states had auditory or visual hallucinations or any other type of experience through which personality states could communicate. Though asked to, he did not keep a diary. Hypnosis could easily be induced, but the different personality states did not emerge under hypnosis. The personality switches stopped spontaneously and the patient was still amnesic regarding periods of the "illness." His mother reported that he behaved more childish than in his pre-morbid state. The family stopped the treatment. When he was interviewed one year later by telephone, he and his parents said that he did not have dissociative symptoms any more and he had regained his previous level of

high academic performance.

Emre

Emre was five years and four months old when he admitted to our clinic. He was brought by his mother. Emre had sudden aggressive outbursts during which he broke objects, attacked his friends, his mother, and kindergarten teachers. He also had short periods of trance states; and he heard voices, saw horrifying images, and complained of somatic symptoms, such as headache and nausea, for the previous six months.

He had been looked after by an attendant woman until six months prior to his evaluation. His mother had been aware of the symptoms in the last six months. Sometimes he talked to himself, laughed, and argued with himself for hours. He had temper tantrums, polarized behavior, age-inappropriate sexual interests, and apparently lied.

His IQ was 129 on the Stanford-Binet intelligence test. His EEG was normal. He said that he heard the voices of four girls and six boys, aged four to twelve, in his head. He could see, play, and argue with them when he was alone. One of the girls, "Witch Gamze," had an automatic gun with which she frightened Emre and the other kids. Witch Gamze sometimes beat Emre and broke his toys or frightened him and woke him up during the night. In the third interview Emre said that 12-year-old Cüneyt wanted to talk to us, and turned his back. When he turned round to us again, he introduced himself as Cüneyt. He was the oldest kid and protected Emre and other kids from Witch Gamze. He said that his mother was a friend of Emre's mother. When the therapist asked where Emre was, he pointed to an empty chair and said that Emre was sitting there and listening to them.

Although amnesias in daily life (e.g., several behaviors and talks which Emre did not remember) were described by his parents, there was no amnesia between two alters when they emerged during the therapy sessions. This patient had the "imaginary companionship" type of DID (Kluft, 1991). He described prominent passive influence experiences which suggested the presence of other alter personalities we did not contact. Although we observed a switching between alters only once, without amnesia, clinical features such as his amnesia episodes during daily life, hearing voices inside of the head attributed to several alters, passive influence experiences related to alters, trance-like behavior, headache, somatic complaints, and sudden behavioral fluctuations highly suggested DID in the patient.

No prominent trauma was reported. He had been raised in a restricted environment without friends. Supportive treatment of the family and the mother produced symptomatic relief. The patient dropped out because of the low motivation of the family for treatment.

Nilgün

Nilgün, a 10.5-year-old primary school girl was brought

to the emergency psychiatric unit of the child psychiatry clinic by her father. Her symptoms were boredom, sadness, long spells of crying without any reason, loss of appetite, trance states, fainting, sudden onset of severe headaches, nausea and stomach pain, difficulty in sleeping, disturbance in school adaptation, and extreme agitation when she got angry.

These complaints appeared one month prior to the assessment. She had been observed laughing, talking to herself, and even arguing as if there was someone else near her. Somatic symptoms and trance states affected her school performance.

Depressive themes dominated her thought content. She had a very high score on the Child Depression Scale. She was diagnosed by two different psychiatrists as having depression. Medical work-up including neurological examination and EEG was normal. Her IQ was 124 measured by the Cattell 2A intelligence test.

During the first interview, Nilgün said that there was an older girl inside her, called Fatma. Nilgün had been hearing her voice almost every day for 2.5 months. This voice supported and comforted her, tried to defend her rights, and commented on her behavior, feelings, and thoughts. She used to say that Nilgün would get well and the future would be better. She warned Nilgün not to tell anything to other people including the therapist.

Although Fatma refused the therapist at first, she then talked via Nilgün and in the second session Fatma took full control. She told us that she had got into Nilgün following a disastrous event that only she knew about, in order to support Nilgün. She claimed that her parents were different from Nilgün's. She said that she took control many times in order to help Nilgün but Nilgün did not know what she did, because Nilgün did not watch her. She said she did not know everything Nilgün did. When Fatma took full control, Nilgün's mimics, speech, and manner of relating with people changed. She looked serious, gave short answers. Nilgün liked to play with toys and puzzles in the interview room. But Fatma was not interested in them and she said she was too old to play with toys. She claimed that Nilgün was inside her. Although Nilgün was a little blond girl with blue eyes, Fatma described herself as tall, having brown eyes and hair. Nilgün was amnesic for the periods in which Fatma took control. The patient left the treatment after symptomatic relief in six sessions without disclosing her traumatic experience.

DISCUSSION

Congruence of the clinical presentation of our patients with those reported from North America support the trans-cultural validity of DID as a diagnostic category in children. Independent studies with standardized clinical instruments for evaluation of these patients will further clarify the debate about the validity of childhood DID.

Our cases show a number of the DID symptoms men-

tioned in previous case reports of childhood DID and several symptoms noted in adult DID patients (Fagan & McMahon, 1984; Kluft, 1984; Weiss et al., 1985; Malenbaum & Russel, 1987; Vincent & Pickering, 1988; Hornstein & Tyson, 1991). Besides the similarity in clinical presentation, the manner of admission to our clinic, previous diagnoses, familial features were also similar to previously reported cases of childhood DID. We also observed that the opposition of Turkish child psychiatrists who were not familiar with DID was similar to that encountered in other countries.

We grouped the signs, symptoms, and behavior of our patients conceptually into a number of categories as offered by Putnam (Putnam, 1991b). These categories include: 1) dissociative symptoms, 2) process symptoms, 3) behavioral symptoms, 4) affective symptoms, and 5) post-traumatic symptoms. Dissociative symptoms (trance-like states, amnesias, and perplexing behavioral fluctuations) were found in all of our cases. Process symptoms such as passive influence experiences (5/5) and auditory hallucinations (4/5) were also common. Trance-like behavior and dramatic behavioral fluctuations have been reported in 100% of published child DID cases to date. These two symptoms were also the most outstanding chief complaints of the parents; however, only one mother complained about her child's auditory hallucinations. Generally all of the patients could hide their symptoms successfully except for their trance-like states. Behavioral problems have been frequently reported in children with DID. Conduct problems were present in all (5/5) of our patients; Age-inappropriate sexual interest and sexualized behavior were present in two (2/5) and self-destructive behavior was present in one (1/5) of our patients. Among these symptoms, aggressive behavior was a common complaint of the families. Explosive anger, the most common affective symptom, was one of the main causes for referral and was present in all of our patients. Two of our patients (2/5) had depression. The rate of depression was higher in previous reports of children with DID (Kluft, 1985a; Fagan & McMahon, 1984). In all age groups of DID patients in Turkey (Tutkun, Yargic, & Sar, 1995; Yargic, Tutkun, Sar, & Zoroglu, 1995) depressive disorder is less common compared to the case series reported from North America; however, explosive anger, aggressive behavior, and self-mutilation are more common.

Severe headache was the chief complaint of one of the patients and his headache had been previously explained by two different diagnoses. Headache was present in four of our patients and it was the most prominent somatic symptom. Two patients complained about stomach pain and nausea. All of the somatic symptoms appeared episodically following a stressful situation and then disappeared completely.

Symptoms of dissomnia such as initial insomnia, frequent waking, and symptoms of parasomnia such as nightmares, pavor nocturnus, somnambulism were present in all (5/5) of our patients. Two patients had symptoms of post-traumatic stress disorder related to sexual abuse (Hale) or physical

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TABLE 1
Childhood MPD Predictors

Predictor	Data From Five Cases					Our Cases Positive For Pred.	Kluft's Cases Positive For Pred.
	1	2	3	4	5		
1. Intermittent depression	+	-	-	-	+	2/5	5/5
2. Autohypnotic/trance-like behaviors	+	+	+	+	+	5/5	5/5
3. Fluctuations in abilities, age-appropriateness, moods	+	+	+	+	+	5/5	5/5
4. Amnesia	+	+	+	+	+	5/5	4/4
5. Hallucinated voices	+	+	-	+	+	4/5	4/5
6. Passive influence experiences, phenomena-suggesting	+	+	+	+	+	5/5	5/5
7. Currently active imaginary companionship	-	-	-	+	-	1/5	0/5
8. Disavowed polarized behavior (aggressive, "too good")	+	+	+	+	+	5/5	4/5
9. Called a liar	+	+	+	+	+	5/5	4/5
10. Disavowed witnessed behavior	+	+	+	+	+	5/5	5/5
11. Muted signs of adult MPD	+	+	+	+	+	5/5	5/5
12. Attenuated expressions of MPD	+	+	+	+	+	5/5	5/5
13. Inconsistent school behavior	+	+	+	+	+	5/5	5/5
14. Refractory to previous therapy	+	N/A	N/A	N/A	N/A	1/1	2/2
15. Dissociators in family	-	+	-	-	-	1/5	3/3
16. Other DSM IV diagnosis is possible	+	+	-	+	+	4/5	5/5
Total predictor score (Kluft 1985)	14/16	13/15	10/15	13/15	13/15		
CDC Scores of patients (Putnam 1993) with 20 items.	21	19	-	22	18	Median-20	

abuse (Mine).

Two patients (Hale and Mine) presented with brief pseudopsychotic episodes. These episodes were characterized by vivid visual and auditory hallucinations, motor excitation, aggressive behavior towards self and others; during these episodes the patient was either not cooperative at all, or could be dealt only with with great difficulty; incoherence of thought and rapid affect fluctuations were prominent. When these symptoms resolved completely approximately one hour later, the patients were amnesic for the episode.

Some clinical features of our cases were classified according to Kluft's (1985a) "childhood MPD predictors" list in Table 1. Our cases have many of these predictors. This suggests that our cases are quite similar to those reported in North America. The clinical features of our five cases are similar to those reported by Kluft (1985a). The presentations of these five patients varied considerably in their resemblance to the adult form of DID. We agree with Kluft (1985a) that childhood cases are likely to be less complex than adult cases, and that in some, alter personalities are but vaguely formed. In child MPD cases, Kluft (1985a) pointed out that the dominant personality determines behavior, that personalities are less complex, that personalities do not have strong narcissistic investments in retaining separateness, and that personalities consciously do not elaborate or emphasize their differences. There were no special purpose fragments, special personalities and/or coalitions which handle school or work. Children have poor skills in covering up time loss and perceive their condition less ego syntonic.

However, our cases were different from Kluft's in some aspects. Although Kluft (1985a) mentioned that severe headache was not reported in children, it was present in four of our cases. The number of personalities in cases reported by Kluft is two to six, totalling 20 in five patients. Our cases have two to eleven alters, totalling thirty-one. Although child cases with DID usually do not have personality systems, one of our cases (Hale) had two systems of personalities and adult-like alter personalities. This patient's clinical presentation was similar to that of adult DID cases. She had severe headaches, somatic complaints, conversion symptoms, self-mutilative behavior, suicide threats, and PTSD symptoms. This child reported sexual abuse additional to physical and emotional abuse.

Clinical experience suggests that the phenomenology of the alter personality systems of children and adolescents may also vary greatly, with a tendency for there to be more crystallized, adult-like alter personalities present in older children (Putnam, 1991b), as seen in our case, Hale. Younger children have more externalized imaginary companion-like alters or have alters that are primarily manifested as passive influence experiences and rarely take executive control of the child's behavioral state (Putnam, 1991b), as seen in our case, Emre.

We could treat only one of the presented cases successfully (Hale, 10.5 years old). She was treated for 26 weeks,

reached fusion easily, and stopped the treatment a few weeks after fusion. This patient's home is 200 km away from our clinic, so we can follow this patient only by phone. She and her parents inform us that she is maintaining fusion.

The study of childhood dissociative disorders in Turkey is in its infancy, but it is evident that dissociative symptoms of adult patients can start in childhood. The Child and Adolescent Psychiatry Outpatient Clinic of our University Department has nearly 5,000 admissions per year. Here, we are presenting the first consecutive five cases diagnosed as DID in 1994. We diagnosed eight patients as having DID and 12 patients as having DDNOS (including four possession cases) during the whole year, who were younger than 11 years of age. Only one of the cases with DID and one case with DDNOS were treated successfully. The psychotherapies of 11 patients are progressing, and others dropped out after rapid symptomatic improvement. One probable reason for patient's dropping out would be ongoing abuse. The lack of inpatient treatment facilities for this age group and the insufficiency of the social support systems in our country (except paradoxically the family of the child, which usually brings the child to treatment) restrict our opportunities for intervention.

These patients have increased our awareness about childhood traumas. Now that all patients are routinely asked whether they have experienced any of the various types of trauma, increased number of dissociative cases are recognized, and we are attempting to carry out the necessary familial and social interventions. ■

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