Child Abuse as an Antecedent of Multiple Personality Disorder

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Until recently, few cases of multiple personality disorder were diagnosed in children. Today, the number of cases is increasing at an alarming rate and appears to be most closely associated with repeated sexual and physical abuse. This paper focuses on reports of childhood multiple personality disorder in the literature, the etiology of this disorder, family dynamics, the differences between childhood and adult multiple personality disorder, credibility problems in children, reasons for failure to diagnose multiple personality disorder in children, treatment, and signs and symptoms to look for in the clinical setting.

Early Reports of Childhood Multiple Personality Disorder

Before the 1980s, accounts of childhood multiple personality disorder in the literature were rare. Although ancient literature cites many examples of demonic possession, which might be classified today as multiple personality disorder, only one medical account of
childhood multiple personality disorder exists in the literature before 1979. This documented case was reported by Despine in 1840 (Ellenberger, 1970) and concerned an 11-year-old Swiss girl named Estelle. The child was thought to be paralyzed due to a fall in which she received a blow to her spinal cord. Estelle’s pain was so severe that she screamed if touched by anyone other than her aunt or mother. She hallucinated and had memory lapses. Estelle’s mother told Despine that Estelle had been visited by angels who comforted her. Despine suspected that this might be a condition that would respond well to hypnosis and began treating Estelle with hypnosis. While under hypnosis, Estelle took on a different personality and informed the physician that her name was Angeline. Angeline soon began to take an active part in Estelle’s treatment. In the waking state, Estelle remained depressed, rigid, and paralyzed and wanted her mother present at all times. While under hypnosis, however, Angeline took control of the personality; she appeared less formal, walked, and preferred that her mother leave the room (Ellenberger, 1970).

A case of adolescent multiple personality disorder was reported by Azam in the 1800s (Bliss, 1986) and concerned a 15-year-old girl named Felida. Felida was first treated by Azam in 1858. Her symptoms included eating disturbances, motor problems, agitation, pain, and a variety of hysterical symptoms. She was described as being a timid, depressed adolescent. At times, however, she would go into a trancelike state and remain in this state for a few hours. She would appear to wake from the trance suddenly but would have no memory of what had transpired only moments before (Bliss, 1986).

Since 1979, numerous cases of childhood multiple personality disorder have appeared in the literature. One of the more interesting cases is that of Cindy, a 3-year-old girl who had been followed since the age of 14 months. She was referred by an attorney for evaluation in a custody dispute. Cindy had lived with her foster parents since she was 2 days old and they wanted to adopt her. When Cindy was 1 year old, however, her biological mother requested custody of her. As was customary, the court requested a psychological evaluation of the child before making a decision. At that time, Cindy was found to be a curious, secure child who did not become anxious when her foster mother was out of the room. The court decided that it would be easier for Cindy to make the transition from her foster mother’s home to her biological mother’s home if it were gradual. The court granted Cindy’s biological mother visitation privileges in the foster mother’s home. At 16 months of age, Cindy was reevaluated. This time she appeared much less secure and clung to her foster mother. Her foster mother reported that Cindy was sleeping poorly, had a decreased appetite, and had fits of anger. Despite these findings, the court ordered that Cindy’s biological mother be permitted to take Cindy for overnight visits. At 23 months of age, Cindy began to beg her foster mother not to make her go with her biological mother, but her foster mother thought this was a reaction to the fact that she, the foster mother, had recently adopted a baby girl. Cindy was forced to go with the biological mother. Shortly afterward, Cindy began to report physical and sexual abuse. On one occasion she returned home with a large hematoma on her earlobe. She also reported that when she was at her biological mother’s home she was called Lila (Riley & Mead, 1988).

At 30 months of age, Cindy was withdrawn, insisted on being held, and cried if her foster mother was out of sight. Because of this, the court discontinued the overnight visits, and Cindy began to improve a little, even though she continued to report physical and sexual abuse during the daytime visits to her biological mother’s home. Cindy’s foster mother was deeply concerned and decided to make an unexpected visit to the biological mother’s home while Cindy was there. She was surprised to discover that Cindy did not seem to recognize her. At this point, Dr. Riley, the court-appointed psychiatrist, began videotaping his sessions with Cindy. During the first taping, Cindy’s foster mother was present. Cindy exhibited two different personalities at this time. One personality appeared to be age appropriate but denied visiting the biological mother. The other personality was immature and puppetlike but reported the abuses that had occurred in the biological mother’s home. During the second session, Cindy’s biological mother was present. On this occasion, Cindy asked to be called Lila, and when questioned about her foster mother’s home, she either said she did not know or did not respond at all. Shortly after this, the courts terminated all of the biological mother’s visitation rights. In time, Cindy was successfully treated and permitted to remain with her foster mother (Riley & Mead, 1988).

Since 1980, Klutf (1984, 1985), Fagan and McMahon (1984), and Braun (1986) have reported numerous cases of childhood multiple personality disorder.

Symptoms and Characteristics

The symptoms of childhood multiple personality disorder may include many diverse behaviors: change in behavior, hallucinations, trancelike states, amnesia, depression, and marked variation in abilities such as reading, problem solving, music, and social skills (Coons, 1986; Klutf, 1984). Many children with multiple personality disorder have been described as liars. Some have imaginary companions. Klutf (1984) treated a 9-year-old boy with multiple personality dis-
order who had been referred to the school counselor who had "assessed him because of his deteriorating grades, his fluctuations of appearance, attitude and competence, and his isolation from his peers" (pp. 125–126). The counselor learned from the boy's mother that he heard voices, exhibited somnambulistic behavior, had frequent nightmares, spoke in different voices, and was considered to be a liar. She also spoke of his poor memory. The school counselor feared that the boy was possessed.

Kluft (1984) also described the case of another 9-year-old boy who had been severely depressed and had attempted suicide. The boy had failing grades in school, was unable to get along with the other children, and ran away frequently. On many occasions, he denied awareness of his behavior of only moments before and often appeared to be in a trancelike state. His cognitive abilities fluctuated greatly from one point in time to another. He was observed to exhibit two different styles of behavior. One was that of a depressed, lethargic child, and the other was that of an alert, vigorous, aggressive child who got into a great deal of trouble. In the depressed state, he could not remember many of the actions of the aggressive state, but in the aggressive state, he could recall all the events that happened in the depressed state. In each of the two states, he exhibited unique voice, speech, and movement characteristics.

**Etiology**

Although the etiology of multiple personality disorder is unknown, various reports support the theory that it is a dissociative response to early childhood trauma (Coons, 1986; Kluft, 1984; Putnam, Guroff, Silberman, Barban, & Post, 1986; Wilbur, 1984). In a review of 100 cases of multiple personality disorder, Putnam et al. reported that childhood sexual abuse was the most common form of trauma, occurring in 83% of the cases. In 68% of the cases, the sexual abuse took the form of incest. Repeated physical abuse occurred in 75% of the cases, and 68% of the cases involved both physical and sexual abuse.

Kluft (1984) suggested a 4-factor theory, which he thought comprised the conditions necessary for the development of multiple personality disorder. Factor 1 is the internal capacity to dissociate, which may be inherited. Factor 2 is the occurrence of overwhelming trauma that necessitates the use of dissociation as a defense mechanism. Physical or sexual abuse perpetrated by a parent could certainly be considered an overwhelming trauma. Factor 3 is the development of the personality around an imaginary companion, ego states, hidden observer structures, or other such phenomena, which prevents the personality from achieving a cohesive self. Factor 4 is the failure of significant others to protect the child from further trauma or to provide positive and nurturing interactions that might give the child the support necessary to endure the trauma and develop normally.

Braun (1986) suggested another theory, the double-bind phenomenon, as primary to the development of multiple personality disorder. In the double-bind situation, the child receives a primary injunction from a loved one along with a secondary injunction that contradicts the first. Additionally, the child receives a nonverbal but powerfully implied and enforced rule that this paradox may not be discussed. An example of a double-bind situation is that of a child who is beaten and raped by her father. While he is brutalizing her, he tells her that he is doing this for her own good because he loves her. The child then tries to tell her mother of this horror but is accused of lying and told that she is a bad girl for daring to say such things about her father. Braun (1986) pointed out that this brutality from a stranger would in itself be traumatic, but coming from a loved one “it has the bizarre quality of combining intense and longed for attention from the parent with pain and humiliation” (p. 69). The child is left with feelings of fear, humiliation, and pain, contrasted with the desire for love and affection and the belief that the abuse is his or her own fault. The child is forced to become two contradictory people: one who is dependent, passive, and eager to please; the other who is angry, hostile, and noncompliant. Eventually, the child may be forced to split repeatedly in an attempt to adapt and protect the self from this irrational environment.

**Family Dynamics**

Little information exists in the literature concerning the families of persons with multiple personality disorder. The high prevalence of physical and sexual abuse, however, is reported frequently. The literature on abusive families is prolific. By applying this information to the family with a member with multiple personality disorder, we can make certain assumptions concerning family dynamics. The first assumption is that the family is highly dysfunctional. The second assumption is that the family has one or more of the following characteristics: (a) one or both parents or guardians were raised in a dysfunctional family that engaged in physical or sexual abuse of the children; (b) one or both parents or guardians abuse alcohol or drugs; (c) one or both parents or guardians are emotionally disturbed and become violent when stressed; (d) one or both parents or guardians are sex addicts, and their interests are not limited to consenting adults (children may actually be preferred); and (e) one or both parents or guardians are members of a cult that practices violent acts (Goodwin, 1988; Steele, 1980).
Abusive parents often suffer from feelings of inadequacy, have a poor sense of personal identity, have infrequent sexual relations with their spouse or another consenting adult, have chaotic family relationships that lack emotional support, tend to be socially isolated, and have a history of being abused and emotionally deprived as children (Steele, 1980). Mothers of abused children are often found either to be oblivious of the abuse because of substance abuse or another form of mental illness or to overlook the abuse for fear of being abused themselves or of losing their husband or lover. In many cases, these women's mothers also failed to protect them from physical or sexual abuse (Justice & Justice, 1979; Steele, 1980).

Stern (1984) studied 8 patients with multiple personality disorder and reported that in addition to child abuse and neglect, severe pathology existed in one or more members of the immediate family. He also noted that 4 of the 8 patients had very religious families, and 1 patient had a foster family that was religious. Perhaps abuse and neglect combined with an exaggerated sense of good and bad makes one more vulnerable to a dissociative disorder.

Persons with multiple personality disorder may be at increased risk of having children with psychiatric disorders. Coons (1985) followed 20 patients with multiple personality disorder over a 10-year period. At the end of the 10 years, 12 of the 20 patients were found to have no children, and the remaining 8 had produced a total of 23 children (15 boys, 8 girls). Of these 23 children, 9 (39%) had already been diagnosed with psychiatric disorders. It is interesting to note that the prevalence of mental illness was much higher in the boys (53%, as compared with 12% in the girls). Only 2 children (9%) were diagnosed as having dissociative disorder. It is important to note that of the 9 children with psychiatric disturbances, 8 came from just four families. These families were characterized by serious marital problems as well as marked severity with respect to the patient's multiple personality disorder.

Differences Between Childhood and Adult Multiple Personality Disorder

Although there are similarities between children and adults with multiple personality disorder, there are also marked differences. In the adult, change from one personality to another is more obvious. In the child, the change is more subtle and may be attributed to the child's impulsiveness or moodiness. Even a child's request to be addressed by another name may not appear to be unusual, because many children find another name more appealing and often ask parents to change their name or call them by their preferred name.

Children tend to have fewer alter personalities than adults. An alter personality is another personality in the same body. The average number of alter personalities reported in children is 4, with a range of 2 to 6, whereas the average number reported in adults is 13, with a range of 2 to over 100 (Coons, 1986).

Adults with multiple personality disorder appear to experience depression and somatic complaints more frequently than do children with multiple personality disorder. It is important to note, however, that depression and suicidal behavior in children with multiple personality disorder is common. Children and adults with multiple personality disorder experience about the same frequency of amnesia and inner voice phenomena. The major difference between children and adults with multiple personality disorder is the length of therapy; children generally require only a few months of therapy, whereas adults often require years of therapy (Coons, 1986).

Credibility Problems and Failure to Diagnose Multiple Personality Disorder

Children who have been brutally victimized may be too frightened to report their experiences, but many do tell a parent, a teacher, or another person who could make a difference. Even so, many are not believed. Why does this occur? If the child goes to the mother, the mother may fear for her own life or may be afraid that the father will leave her if she takes action. If the child goes to a teacher or someone else, that person may have difficulty dealing with this information due to his or her own life experiences. If this person was abused as a child, has difficulty with impulse control, or has a spouse with violent outbursts who is suspected of physically or sexually abusing a child, the person may find it difficult to take the appropriate action or to be objective. Disbelieving the child is a way in which a person avoids dealing with these conflicts. If the child's accounts of abuse are horrifying or bizarre, and the person he or she tells has little experience with such things, the child may be disbelieved. Goodwin (1985) reported that stories that have been disbelieved by physicians "include those involving genital mutilation, the placing of objects into the vaginal, anal or urethral openings, incest with multiple family members, incest pregnancies, and the protracted ignoring or locking up of children" (p. 8). When children are believed, the family's rage may be such that it terrifies either the child or the professional to the point where one or both recant the accusation.

Young children tend to mix fantasy with reality and often express memories through play or through physical symptoms rather than through the use of words. The child may violate dolls, injure small ani-
mals, or complain of pain in various body parts. Even the skilled observer may not always understand this symbolic representation. Older children are better able to describe the abuse, but accounts of the incident may be told without emotion or without the appropriate emotion. For example, the child may describe being beaten and raped in the same way she might describe a walk to school, or she may even smile while relating the experience. Traumatized children may also be disbelieved because of their tendency to distort reality. They may distort the time sequence, have major perceptual or cognitive distortions, or even hallucinate. The more severely traumatized the child is, the more likely it is that he or she will distort reality and thus the greater the likelihood of being disbelieved. This disbelief may in itself contribute to the development of multiple personality disorder (Goodwin, 1985), because the child may begin to distrust his or her own perceptions and to repress painful events.

Although multiple personality disorder is a condition that generally develops in childhood, it is seldom diagnosed before late adolescence or adulthood, probably because many physicians still believe that multiple personality disorder is a rare condition and consequently pursue other explanations for the child's behavior. Because the personality changes are subtle, the physician may not even consider multiple personality disorder.

Treatment

Children with multiple personality disorder tend to respond well to therapy and require far less time in treatment than do adults. When the family is cooperative and care is taken to protect the child, the child can often be left with the family and treated as an outpatient. Generally, the family is also involved in therapy and must agree to have a child welfare agency provide continued monitoring and follow-up. In severe cases in which the child's safety cannot be assured or the child is potentially suicidal, he or she is removed from the family and treated in a hospital or other sheltered environment. Adolescents generally require longer treatment than children and often must be hospitalized to interrupt acting-out or suicidal behavior. Treatment of young children usually involves play therapy, hypnotism, and family therapy. Older children are treated with verbal therapy, hypnotism, and family therapy (Coons, 1986; Fagan & McMahon, 1984; Kluft, 1985).

Occupational therapists can use such projective techniques as drawing, painting, clay sculpting, collage making, puppetry, and creative writing to help the child express feelings and emotions that are too painful to express verbally. Some of the creations may be horrifying and repulsive, reflecting the terror these children have experienced. These children need to be accepted as they are. The therapist must not be eager to make interpretations, but should instead provide opportunities for the child to make his or her own interpretations when ready to do so. The therapist should be consistent and caring, but should not be surprised if the child appears fearful or suspicious of motives. Some of these children do not want to be touched and experience even the most caring touch as frightening or painful. They have learned that adults inflict pain and are not to be trusted. One must always be alert to the potential for self-harm and violent outbursts. The therapist can protect the child by maintaining a stimulating but safe environment.

Signs and Symptoms in the Clinical Setting

Occupational therapists who work in the school system, in pediatric settings, and in child and adolescent psychiatry should be alert to the signs and symptoms of multiple personality disorder in children, as listed below:

1. Has a history of child abuse, especially repeated, violent sexual abuse.
2. Displays autohypnotic, trancelike behavior.
3. Has amnesia.
4. Displays fluctuating abilities (physical or mental) or inconsistent school behavior.
5. Hears hallucinated voices.
6. Is accused of lying.
7. Refers to self in third person or asks to be called by another name.
8. Has dissociators in family.
9. Has been diagnosed as having other mental or emotional problems (Kluft, 1985; Putnam et al., 1986).

If several of these characteristics are present, especially the first four, the therapist should ask the physician if multiple personality disorder has been considered.

Summary

Multiple personality disorder generally develops in childhood, but often is not diagnosed until adolescence or young adulthood. When treated early, children with multiple personality disorder have a good prognosis for complete recovery. Occupational therapists working in pediatrics can become more alert to the signs and symptoms of multiple personality disorder in children. Because most of these children have been physically or sexually abused, they often do not trust adults. This mistrust is exhibited in the form of shy, withdrawn behavior; overcompliance; or hostility and aggression. Sensitivity is needed in work
with the child and his or her parents. Therapists from abusive families or those who have experienced severe psychological trauma must carefully assess their own needs and may need help in working through their own trauma before working with children or adults with multiple personality disorder.

References


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