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DIAGNOSTIC EVALUATION OF THE CHILD WITH DISSOCIATIVE IDENTITY DISORDER/MULTIPLE PERSONALITY DISORDER

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When children are the victims of early, ongoing, extraordinary trauma, whether physical, sexual, or psychological, they cannot endure it. In order to survive they must find some means of escape. Physical escape is usually impossible (although we have treated one child with dissociative identity disorder/multiple personality disorder [DID/MPD] who twice ran away from home at 2.5 years of age). The young and immature human organism, however, seems to be endowed with an innate capacity to escape mentally from situations that are physically and emotionally intolerable. It would appear that a child's intrinsic ability to lose himself or herself in fantasy play to a far greater degree than any adult has special survival value. When children are repeatedly subjected to intolerable pain they dissociate; that is, they seem to self-hypnotize and in so doing carry themselves to safety. To them, the event is not happening, or it is happening to someone else. They are safe in some sanctuary of the mind that is available to the young. What is more, the perceptions, thoughts, and feelings surrounding the trauma are themselves encapsulated; they are cut off from consciousness and unavailable for normal recall. It is as though nature had provided the most vulnerable with a special survival mechanism. Dissociation functions as an automatic, primitive, protective, psychological defense against excruciating physical and mental pain.

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Dissociation is not always pathologic by any means. We all, from time to time, lose ourselves in fantasy. What adult has not missed a subway stop or the exit off a highway while imagining a romantic encounter or the confrontation with an irascible boss? In children, an intense fantasy life is part of normal development. Play is practice for life. Dissociation in children and adults occurs along a continuum that extends from normal daydreaming, accompanied by brief lapses of attention, to the appearance of alternate personalities that take control of the person's behavior. This article focuses on the diagnostic evaluation in children of the most severely pathologic manifestation of dissociation, DID/MPD.

OBSTACLES TO DIAGNOSIS

The Fleeting and Less Fixed Nature of Children's Symptomatology

One might expect so dramatic a disorder as DID/MPD to be easily recognizable. Such is not the case, especially in children. The characteristics of different personality states in children may be less fixed and well defined than in adult patients. What is more, their appearance and disappearance are often fleeting and therefore difficult to recognize. The sudden violent flash of an angry alternate personality is likely to be dismissed as a child's momentary fit of pique. The clinician must keep in mind that DID/MPD is a secret disorder, hidden from the child as well as from the clinician.

Confusion With Normal Fantasy Life

Many of the signs and symptoms commonly seen in children with DID/MPD are easily confused with normal fantasy life. For example, children with DID/MPD often have extremely vivid imaginary friends with whom they talk and play. Over time, in many cases, these imagined characters become the matrices around which alternate personalities form; they acquire a life history of their own. To the parent observing or overhearing exchanges between the child and such characters, however, the child appears to be play-acting, simply taking on different roles. Similarly, the conversations of a child with the hallucinated voice of an alternate personality tend to be dismissed by parents, and often by clinicians as well, as the manifestations of a somewhat overactive fantasy life. In young children, certainly in those of an age of less than 6 or 7 years, the distinction between normal fantasy life and pathologic dissociation is extremely hard to make. We have found, however, when

comparing the fantasy life and the imaginary companions of normal children with those of severely abused, dissociative children, that in normal children imaginary companions usually disappear by 7 years of age. In dissociative children they linger far longer and often accompany the child into adolescence. Furthermore, whereas in normal children imaginary companions are helpers and playmates, some of the imaginary companions of dissociative children are malign. They tell the child to do bad things, to hurt him- or herself or to hurt others.

The determination of whether or not specific dissociative symptoms in children are adaptive or pathologic rests on clinical judgment. The more familiar the clinician is with normal children's play, the more astute will be that clinician's judgment. Suffice it to say that when dissociative symptoms interfere with attention, concentration, reality testing, sense of identity, and overall functioning they have exceeded the normal and the clinician must pay attention. Our efforts to take into account the normal variations in children's developmental levels and tendencies to fantasize, and our attempts to refrain from overdiagnosis, may, in the case of children with DID/MPD, lead us to overlook or misinterpret important evidence of severe psychopathology.

Confusion With Other Psychiatric Disorders

Children who suffer from DID/MPD present with a plethora of signs, symptoms, and behaviors, most of which are also characteristic of other diagnoses. For this reason the child, like his or her adult counterparts, may present for evaluation having already received a multiplicity of other diagnoses, having undergone a variety of more or less intrusive diagnostic procedures, and having been treated with several different classes of medications. It is common for such children to present to clinicians with histories of having received stimulants, antidepressants, or neuroleptics at different times, depending on the symptoms considered most problematic at the times of previous evaluations. Thus, when a child presents with a history of numerous different kinds of symptoms and a variety of previous diagnoses and interventions, this picture should alert the clinician to the possibility that the child may suffer from DID/MPD.

Confusion With Attention-Deficit Hyperactivity Disorder

The three core symptoms of DID/MPD are lapses of awareness, amnesias for events that occur during these lapses, and switches into alternate personality or behavioral states. These kinds of symptoms

wreak havoc with academic and social functioning. Teachers complain that such children daydream and refuse to pay attention. During lapses or trances the children fail to take in the content of the lesson; they then complain that they have never been taught the material. Their performances vary and confuse their teachers. One day their penmanship is elegant; the next it is scrambled, immature, and indecipherable. We have found, especially with boys, that they may suddenly get up from their seats, wander around the classroom, or even walk out of the room. They appear to the teacher to be infinitely distractible, which often results in treatment with stimulant medications.

In the classroom and on the playing field such children are quick to take offense. Both girls and boys often have histories of fights with other children. The ever-changing behavioral and academic picture of severely dissociative children seems to be what leads many clinicians to diagnose attention-deficit hyperactivity disorder. Table 1 on page 310 lists the most common features of DID/MPD that lead to the misdiagnosis of attention-deficit hyperactivity disorder.

Confusion With Schizophrenia

Children who suffer from DID/MPD almost invariably have auditory hallucinations. They hear the voices of alternate personalities in their heads. What is more, the voices they hear often give instructions. Sometimes the advice is helpful, urging them to walk away from fights or to do homework. Often, however, the advice is more sinister. For example, the voices of one of our 9-year-old patients instructed her, "Say dumb to the teacher. Hit the teacher." We have also evaluated children whose voices have told them to jump in front of cars or otherwise hurt themselves. At one time, while hospitalized, the same suicidal 9-year-old heard a voice say, "Look! There's a knife on your bed." We have found, as did Hornstein and Putnam,[7] that command hallucinations are common. Voices often argue with each other, giving the child conflicting instructions (and, incidentally, causing headaches). Usually one voice cautions safe, acceptable behavior; another urges violent, self-destructive acts.

Children with DID/MPD often have an elaborate fantasy about where the voices in their heads come from or live; they conceptualize a hierarchy of who is in charge and how each voice or character functions in the system. These beliefs could be characterized as delusional. Children with DID/MPD are not aware of the fact that periodically these voices or imaginary beings take control and stand in for them.

Children with DID/MPD live in a perpetual state of confusion. They are never really sure where they have been, what they have done, or what has been done to them. They frequently contradict themselves and are impervious to their inconsistencies. Their confused, illogical

thinking further contributes to a misdiagnosis of schizophrenia. Children with DID/MPD will suddenly stop speaking and stare into space. Often this occurs in response to orders from an internal voice, instructing them to stop "spilling the beans." These episodes mimic the "blocking" that generations of clinicians have been taught to associate with schizophrenia. One severely sexually abused 7-year-old with DID/MPD, when asked about what had happened to her, responded, "I don't know, but I told you already." Several children whom we have evaluated have spontaneously volunteered that they did not know whether certain events in their lives were real or whether they had dreamed them.

In short, the command auditory hallucinations, the experience of hearing voices speaking to each other in one's head, the sense of being controlled by these voices, the delusional system of hierarchies of imaginary companions, the blocking, and the illogical thinking of children with DID/MPD often lead to a misdiagnosis of schizophrenia. The major characteristics shared by DID/MPD and schizophrenia are listed in Table 1.

Confusion With Mood Disorders

Children who suffer from DID/MPD are extremely changeable. They can be pleasant and agreeable at one time and whiny and tearful at another. Different personalities have had different kinds of experiences and, therefore, different memories. Those who have taken the brunt of the abuse are often chronically sad and angry. Those who have been spared are often of good cheer. The differences between the child's presentations during these states often lead clinicians to diagnose a mood disorder, unipolar if only the misery is observed, bipolar if the clinician meets both happy and depressed personalities. Table 1 lists some of the characteristics of children with DID/MPD that lead to an erroneous diagnosis of a mood disorder. The diagnosis of a mood disorder is among the most common misdiagnoses made.[7] Of course, dissociative children who have been abused also may suffer from a depressive disorder. The disorders are not mutually exclusive.

Confusion With Seizure Disorders and Narcolepsy

The trance-like states and circumscribed amnesias characteristic of DID/MPD can cause clinicians to diagnose some type of seizure disorder. When children simply stare off into space and are unresponsive, petit mal is suspected. When the child engages in complex behaviors for which memory is later impaired or absent, a diagnosis of complex partial seizures may be entertained. Sometimes, in addition to these kinds of

lapses, children actually appear to be having grand mal seizures. We recently evaluated a teenager whose seizure-like episodes were manifested by falling to the floor and losing consciousness. A complete neurologic evaluation, including electroencephalograms and a magenetic resonance image of the brain, were negative. What is more, we discovered that consciousness could be restored by suggesting to the apparently unconscious girl that the voices in her head calm down and become silent, and that at the count of three she will awaken. Unfortunately, this young girl experienced one of her episodes while in the company of caretakers who were unfamiliar with her condition. She was brought to an emergency room where doctors, alarmed by her dramatic presentation, infused her with diazepam and phenytoin, intubated her, and placed her on a respirator in the intensive care unit before they realized the nature of their error.

Another severely traumatized 10-year-old child with DID/MPD came to our clinic with a diagnosis of narcolepsy. Periodically, and with no apparent precipitant, the child would seem to fall fast asleep. Previous treatment with stimulant medication had had no effect on these behaviors. At the beginning of treatment this child revealed to us two different alternate personalities, a squeaky-voiced baby and a fleet-footed cat. From time to time, when she felt threatened, she would either have a sleep attack, turn into a helpless infant, or become a cat, dropping to the floor and slinking under the table. She had no recollection of her behaviors while in her regressed or animal personality states. As her household became more stable, this child ceased to experience sleep attacks, and her animal personality state disappeared. Nevertheless, at times of stress, she continued to switch into an immature, baby-like personality. Table 1 lists the kinds of signs and symptoms that cause the confusion of DID/MPD with seizures and narcolepsy.

Confusion With Borderline States

Severely dissociative children experience numerous different kinds of symptoms that affect moods, interpersonal relationships, and reality testing. Often as a result of repeated sexual abuse they experience a myriad of physical complaints for which no organic explanation can be found. Combinations of moodswings, episodic rages, suicidal and self-mutilating behaviors, psychotic symptoms, unstable relationships, and ill-defined physical complaints lead to the diagnosis of a borderline state. Some of the most common signs and symptoms that cause children with DID/MPD to be labeled borderline are listed in Table 1.

Confusion With Conduct Disorder/Antisocial Personality

Children with DID/MPD are unpredictable. Peers, teachers, and family members never know what to expect. Compliant behavior may

suddenly be interrupted by rageful, even violent acts. Periodic fights with siblings, classmates, and authority figures occur, sometimes without warning. Worse, children with DID/MPD are often unaware of these aggressive acts and deny them. Hence they are called liars. In one personality state they may take objects that belong to others. In another state they have no recollection of these acts. Later, when the objects turn up in their rooms or their pockets, the children are called thieves. Alternate personalities who have been sexually abused often repeat as aggressors what happened to them as victims. Fugue states or deliberate runaway behavior to escape intolerable situations also occur commonly. In different personality states, different names are used. Law enforcement agencies interpret such behavior as an attempt to conceal identity or blame acts on others. Furthermore, a personality that endured pain may show no remorse at all for the violent acts it committed in order to defend the fragile child. This combination of aggressiveness, lying, stealing, sexual assaultiveness, runaway behavior, and lack of remorse frequently leads to diagnoses of conduct disorder in children and antisocial personality disorder in adolescents and adults. The most important symptoms and behaviors leading to this misdiagnosis are listed in Table 1.

The signs, symptoms, and behaviors described above and listed in Table 1 summarize some of the most common presentations of DID/MPD. How does the clinician begin to recognize a disorder that is characterized by so many different kinds of symptoms and behaviors? At present, there are no psychological, medical, or neurologic tests to identify or confirm the diagnosis of DID/MPD. If there is anything about psychological test results that is pathognomonic, it is the child's varied performance within a single testing session or at different testing sessions. For example, the child's responses can vary from normal to psychotic, depending on the child's personality state at the time a question is asked. Fluctuations in the child's developmental level of functioning during intelligence testing can lead to confusing results and to a gross underestimate of the child's capabilities. To date, differences among electroencephalograms obtained during different personality states also have been unreliable measures of DID/MPD. With the exception of differences in evoked potentials, actors have been able to reproduce the electoencephalogram changes of DID/MPD.[2, 4, 9, 11, 13] The measurement of different neurophysiologic states (e.g., skin conductance, blood pressure) also is still in its experimental stages and cannot be used diagnostically. In short, the diagnosis still rests on extremely careful, detailed clinical assessment.

OBTAINING A HISTORY

Children with DID/MPD are notoriously poor historians. Much of their early years, especially experiences of abusive treatment, is blocked

Table 1. SIGNS AND SYMPTOMS OF DID/MPD THAT CAUSE IT TO BE CONFUSED WITH OTHER CONDITIONS

Attention-deficit hyperactivity disorder
Restlessness and difficulty concentrating
Fluctuating academic abilities (e.g., math, spelling, language skills)
Tantrums
Problems following instructions
Impaired memory for learned material
Changes in maturity of handwriting
Schizophrenia
Hearing voices
Command hallucinations
Hearing voices talking to each other
Feeling controlled from outside
Having a hierarchy of "imaginary" companions
Apparent illogical thought processes
Apparent blocking
Mood disorder
Mood swings
Episodic rages
Suicidal behaviors
Long periods without sleep
Inappropriate sexual behaviors, hypersexuality
Grandiosity
Self-mutilation
Seizure disorders or narcolepsy
Dreamlike states
Blackouts or loss of time
Episodes of deja vu or jamais vu
Impaired memory for acts, violent and otherwise
Appearing as though in a trance
Out-of-body experiences
Borderline personality disorder
Psychosomatic pain
Mood swings
Binge eating
Suicidal or self-mutilating behaviors
Episodic rages
Unstable interpersonal relationships, poor social adaptation, or impulsivity
Episodic psychotic symptoms
Conduct disorder or antisocial personality
Fights with peers and authority figures
Episodic violence
Apparent lying
Apparent stealing
Inappropriate sexual behaviors
Running away
Use of aliases
Apparent lack of feelings or guilt when describing violent acts

from memory and inaccessible. Time periods are confused with each other and children cannot provide a chronologic account of their lives. They are also unaware of much of their symptomatology. They forget their forgetfulness; they are amnesic for their amnesias. Therefore the clinician must rely on accounts from parents, caretakers, and teachers.

In order to facilitate history taking, several experienced clinicians have created checklists of signs, symptoms, and behaviors that are commonly seen in children who suffer from DID/MPD (see the article by Steinberg elsewhere in this issue).

We have found Putnam's Child Dissociative Checklist[14] to be an extremely useful instrument for parents or caretakers to fill out prior to (or at the beginning of) an evaluation. Parents are asked whether or not they have observed a variety of different kinds of dissociative phenomena in their children, including trances, forgetfulness, time confusion, skill variations, regressive behaviors, lying, physical complaints, inappropriate sexual behaviors, auditory hallucinations, sleep difficulties, imaginary companions, and changes in personality or voice. Responses to these kinds of questions provide a springboard for further inquiry and clues to some of the most promising areas to explore in subsequent interviews with the child.

Whenever possible, we also ask parents or caretakers to respond to the Dissociative Experiences Scale,[1, 3] a questionnaire that explores the parent's or caretaker's own symptomatology. We have found, as have others who have worked in the field of childhood dissociative disorders, that many of the close relatives of children with DID/MPD suffer from similar disorders; the Dissociative Experiences Scale can sometimes be used as a screening tool for identifying dissociation in them. We have also found, however, that responses to the Dissociative Experiences Scale are not always candid, particularly when it is filled out by a family member who feels that he or she has much to hide. Nevertheless, every effort must be made to assess dissociation in family members and caretakers, because some of the adults who are most abusive to the child are also dissociative and hence are unaware of their own acts. A careful family history of symptoms of other kinds of mental illness is also essential. We have found that episodically manic parents can sometimes be fiercely abusive toward a child (see the article by Yeager and Lewis elsewhere in this issue).

PSYCHIATRIC, SOCIAL SERVICE, MEDICAL, AND SCHOOL RECORDS

Many of the children with DID/MPD who are brought to psychiatric services for evaluation have already received treatment elsewhere. Often their families are known to social service agencies. The children's numerous physical complaints frequently have led to many previous

medical examinations and treatments. Academic, interpersonal, and behavioral problems also may have been observed at school. For these reasons, psychiatric, psychological, social, medical, and school records provide a gold mine of relevant information.

For example, in a recent study of dissociative symptoms that we conducted in a sample of children in residential treatment, we discovered that those with the most severe dissociative symptoms usually had been evaluated many times before and had been given a variety of different diagnoses. The two most common diagnoses were attention-deficit hyperactivity disorder and conduct disorder. Social service records revealed that almost all came from violent, chaotic, unpredictable families in which histories of abuse or neglect could almost always be documented. Medical records documented treatment for abdominal pain, urinary tract infections, bowel problems, broken bones, and headaches. Approximately one third of the male abused children we evaluated suffered from encopresis, and in almost every instance a history of sexual abuse could be found.

Probably the most revealing records were educational. Report cards were less informative than were teachers' comments. Teachers who worked with these children daily remarked on the unpredictable nature of the children's behaviors. Children were described as suddenly regressing or behaving like a 4-year-old. The quality of their work was called erratic. The word "sometimes" appeared repeatedly (e.g., "sometimes has excellent penmanship," or "sometimes has immature handwriting"). Teachers also complained of the children's tendency to daydream, failure to concentrate, and inability to sit still.

Thus a review of the psychosocial, medical, and educational records of children suspected of suffering from DID/MPD is invaluable.

PHYSICAL EXAMINATION

At some point in the evaluative process a physical examination is required. The purpose of this examination is fourfold: 1) to obtain a detailed medical history; 2) to assess the nature of specific physical symptoms such as seizure-like episodes, headaches, staring spells, and stomach pains; 3) to reassure the child that his or her body is intact and has not been damaged irreparably; and 4) to document, if possible, evidence of physical or sexual abuse if it has occurred. Children with a suspected diagnosis of DID/MPD should not simply be referred to a pediatrician for a routine examination. Pediatricians must be informed of the clinician's concerns and suspicions. The pediatrician must also be alerted to the likelihood that the child has been sexually abused and cautioned regarding the child's sense of modesty and fears of being violated. A sensitive pediatrician will inform the child of each and every procedure prior to performing it, especially when the examination

involves the genital and anal areas. Every effort should be made to avoid retraumatizing the child by placing him or her in positions previously associated with sexual violations (e.g., knee to chest, legs spread). Children's reactions to physical examinations are often telling. For example, during the course of an examination of her genitalia, one sexually abused, dissociative 3.5-year-old at first screamed and struggled to extricate herself. Moments later she calmly took hold of an examining instrument and attempted to insert it into her vagina.

An essential part of the physical examination is a careful examination of the skin for scars. Children with dissociative disorders often carry signs of physical abuse and self-mutilation all over their bodies, even on their ankles and on the soles of their feet. In adolescents, the evidence of childhood abuse may have faded, and proper lighting is necessary if the old scars from switches and belt buckles are to reveal themselves.

We have found that most of the severely abused, dissociative children whom we have evaluated are either unaware of particular scars or ignorant of their causes. One child entered a trance-like state while we examined her severely scarred back; she emerged from her trance only when that part of the examination was completed. This kind of reaction illustrates how easy it is to retraumatize a child who suffers from DID/MPD.

INTERVIEWING THE CHILD

Fantasy and Imagination

DID/MPD is a secret phenomenon. The instantaneous switches from one mind state or personality to another are hidden, concealed under the guise of a moodswing or sudden change of heart. The vulnerable child is put to sleep or whisked away to a special safe place while a sturdier aspect of the personality handles what is perceived as a threatening situation; and no one is the wiser, not even the child. Like their adult counterparts, children who suffer from DID/MPD are almost invariably unaware of their dissociative disorder. Children do not necessarily deliberately conceal their illness. They often simply do not know it exists.

What do children with DID/MPD know about their condition? What aspects of what they know are they willing to share? The kinds of thoughts, feelings, and experiences that most people consider to be part of normal fantasy life but which, in dissociative children, are more extreme or intense are usually acceptable topics with which to begin. We therefore tend to open our interviews with questions regarding imagination. Does he or she have a good imagination? Can he or she

tell us about some favorite movies or television programs? From there we are able to move easily into questions regarding the child's ability to get lost in fantasy, to "space out," to lose track of time and miss what is going on in the real world. In the context of imaginative play we ask the child about special toys and eventually about make-believe friends or siblings. Having imaginary companions is a normal occurrence. As previously mentioned, however, by age 7 years in normal children most imaginary companions have vanished. We have found that children with DID/MPD retain their fantasized friends, often through adolescence. And their companions, unlike those of their less traumatized peers, do not always lend friendly counsel (see the article by Trujillo et al elsewhere in this issue).

Discussions of superheroes or favorite television characters enable the interviewer to inquire about the child's ability to take on special characteristics. One of our adult patients with DID/MPD suggested the following inquiry, which we have found useful:

> You know the way people can switch channels on a TV set? Well, some kids, if they are in trouble and need to be especially big and strong, or if they want to play around like a baby, can switch and become big and strong, or they can be little, like a baby. Can you ever do that?

In several instances this very question has enabled children and adolescents with DID/MPD to begin to reveal their experiences of switching into powerful alternate personality states.

The Special Place

The topic of imagination also leads naturally to questions about the child's ability to fall into a trance-like state and remove him- or herself from hurtful situations. One of the most useful questions in our repertoire also was suggested to us by an adult who suffered from DID/MPD. He suggested the following:

> Many kids who have been through a lot or have been hurt are able to space out and go to a special place in their heads and not feel it. Can (could) you do that?

We have found that most children who suffer from DID/MPD relate instantly to this sign that we have some understanding of the way they cope with the pain of their existence. (In fact, many adults with DID/MPD also respond eagerly and affirmatively to this type of question.)

Responses to this benign exploration of children's coping mechanisms through fantasy and self-induced trances will be useful in subse-

quent sessions. Later on in the diagnostic and treatment process the interviewer will be able to ask the child to remove him- or herself to the special place and allow an alternate personality to come forward. We have found that the child's ability to escape to a special place spontaneously or at the request of the interviewer obviates the need for formal hypnosis. Subsequently, in the course of treatment, the child can be asked to listen in on conversations with other personalities from the safety of his or her special place. Thus, the special place can be used to facilitate communication between mutually sequestered parts of memory. As can be seen, the clinician's success as diagnostician and therapist for children suffering from DID/MPD depends in great measure on an ability to suspend disbelief and make creative use of the child's fantasy life.

Voices, Imaginary Companions, and Alternate Personalities

The topic of imagination can also be used to explore hallucinatory experiences and delusional thinking. Another approach (again, one suggested to us by an adult with DID/MPD) goes as follows:

> Many children who have been through a lot or who feel lonely can talk with someone in their heads. Can you do this?

This simple, straightforward statement avoids questions about hearing "voices nobody else hears" and turns the potentially threatening topic of auditory hallucinations into a discussion of apparently ordinary fantasy life. Almost every child who suffers from DID/MPD has heard voices in his or her head. Some voices console, some counsel, some give orders, and some intimidate. These voices also talk to each other; they argue over what the child should or should not do. Slowly, gently, the clinician must try to learn what each voice sounds like; which are male, which are female; who gets along with whom; what kinds of advice does each give; and, eventually, what made each come and what were or are his or her functions. Many of these imaginary or hallucinated characters are guardians of experiences and memories that are too painful for the child to remember consciously. Thus, if the clinician wishes to learn about the child, it is necessary to befriend and gain the trust of all. The clinician must resist the understandable tendency to have favorites or to express criticism of nasty, aggressive voices. The angriest and most violent characters in the child's head endured the most, have the most valuable information, and must be respected and liked. Later on, in therapy, they can be helped to use their strength in more constructive ways. The clinician must appreciate that these entities are caricatures, created by a child's mind. Before they disappear or merge with other

personalities, they can be helped to mature and function more appropriately.

Once the clinician has learned about the existence of these internal voices or characters, it is a short step from there to requesting to speak with each of them. Sometimes it is weeks before the child is willing to retreat to his or her special place and a voice or character is willing to come forth. Sometimes this phenomenon occurs in the very first session. It depends on when trust has been established. Direct communication with these secret entities, of course, is a major step in establishing the diagnosis of DID/MPD. Anyone who has treated adults who suffer from DID/MPD probably is familiar with the metamorphosis from internal voices to imaginary companions and finally to alternate personalities.

The question always arises whether what is elicited is genuine, whether it is the result of suggestion, or whether the clinician is being "conned" by the child. Is the clinician really speaking with alternate personalities, that is, with sequestered parts of the child's mind, or is the clinician simply participating in an elaborate game of "let's pretend?" The child's voluntary retreat to a special place and his or her conscious willingness to switch with an alternate look like make-believe or possibly malingering. What is more, children's methods of communicating with or of transferring control to another aspect of personality often look like fantasy play. For example, we have treated one young child who closed her eyes and rested her head on the table in front of her during transitions from one personality state to another. When she raised her head the transition was completed. Similarly, two children with diagnoses best categorized as dissociative disorder not otherwise specified spontaneously closed their eyes and rested their heads on the table when their inner voices spoke to them. They then raised their heads and recounted what the voices had said.

How does the clinician distinguish among dissociative psychopathology, fantasy play, and malingering? The answer to this question is that the diagnosis of DID/MPD does not rest exclusively on the clinician's observations of alternate personality states, although these states must occur in order to make the diagnosis. In cases of DID/MPD there is always an abundance of other supportive and confirmatory data. Ample evidence of trance-like states, amnesias, mood swings, and changeable behaviors; attitudes; and levels of competence can almost always be documented from several different sources.

Special Techniques: Writing and Drawing

Sometimes patients with DID/MPD can write or draw about topics they feel that they must not discuss. With children and adults, the vows made to abusers not to tell can be circumvented with pencils and colored

markers. Therefore, when an abused child becomes tongue-tied, we often ask that child to draw a picture of what happened.

Figure 1 shows the drawing made by an alternate personality of a 17-year-old girl with DID/MPD of her father crawling up into her bunk bed and raping her. Note several different handwritings that reflect the perceptions of different alternate personalities. Note also the way alternates refer to the subject in the third person. After drawing this picture, this adolescent suddenly seemed to lose consciousness, and her head fell forward onto the picture.

The developmental level of the alternate personality who draws the picture is reflected in its style. Very young personalities tend to make stick figures, whereas the drawings of older alternate personalities are more sophisticated. The drawings in Figure 2 were made by alternate personalities of a 10-year-old girl.

We always ask a child to sign each of his or her drawings. Just as drawing styles are different among alternates, so are the handwritings and, sometimes, even the names of the artists. Figure 3 reveals the different names and signatures of alternate personalities of a 9-year-old boy suffering from DID/MPD.

Of note, when children are asked to write out the names of their imaginary friends or of the people they hear in their heads, they frequently write each name differently, using penmanship characteristic of the alternate personality whose name they are writing. Figure 4 illus-

Figure 1. Drawing made by an alternate personality of a 17-year-old girl with DID/MPD.

Figure 2. *A–C,* Drawings made by three different personalities of a 10-year-old girl with DID/MPD.

trates the different names and signatures of alternate personalities of a 10-year-old girl.

Other Relevant Areas of Inquiry

Among clinical investigators who work in the field of DID/MPD in children[5, 7, 8, 10, 12, 15] there is a consensus regarding the kinds of signs, symptoms, and behaviors that are characteristic of children with this disorder which must be explored. These include trance-like or autohypnotic states, amnesias, mood changes, vivid imaginary companions, auditory experiences (including command hallucinations and voices talk-

Figure 3. Three signatures of alternate personalities of a 9-year-old boy with DID/MPD.

Figure 4. Five signatures of alternate personalities of a 10-year-old girl with DID/MPD.

ing to each other), the sense of being controlled or made to perform particular acts, feeling unjustly blamed for unrecalled behaviors (e.g., taking things), denying responsibility for one's acts (e.g., being called a liar), temper outbursts, precocious sexual concerns and behaviors, fluctuations in demeanor, episodic regressive behaviors, voice changes, fluctuating tastes in clothes or foods or friends, fluctuating skills and academic abilities, wishing to be called by different names, being told one seemed "possessed" or like a different person, and having different handwriting styles. Space precludes a detailed discussion of techniques for exploring each of these topics; suffice it to say that all are important.

In addition to emotional and behavioral symptomatology, many children with DID/MPD have a variety of medical complaints. They often suffer from vague gastrointestinal symptoms (e.g., abdominal pain) for which no medical explanation can be found. They may also suffer from constipation, encopresis, and even rectal bleeding as a result of sexual abuse. Genito-urinary complaints, including pain or bleeding on urination and a history of genito-urinary infections, are common.

One of the most common somatic symptoms is headaches. Elaborate work-ups to determine their etiology, however, are usually unproductive. Fainting, staring spells, and even falling and shaking episodes are also common, and the child may present with a history of having been treated for a seizure disorder. Thus, a thorough evaluation must devote almost as much time to exploring medical issues as it does to exploring psychological issues.

The Bellevue Dissociative Disorders Interview for Children

For adolescents, the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) has proved to be a useful diagnostic tool (see the article by Steinberg elsewhere in this issue). At the New York University–Bellevue Hospital Center Dissociative Disorders Clinic, we have designed a protocol for children that covers the topics mentioned above and that phrases questions in ways that are especially sensitive to children's abilities to comprehend. This instrument has been pretested on a sample of 46 normal school children and 23 abused children in residential treatment. The protocol significantly distinguished the two groups from each other. Responses to questions from the protocol were recorded almost verbatim. Subsequent to the interviews, three different reviewers rated responses for the presence or absence of specific symptoms. Agreement among raters was significant ($\kappa = 0.78$).

In the course of pilot testing this interview protocol, it became clear that severely behaviorally disturbed, dissociative children could not concentrate and sit still long enough to go through the interview sequentially. They were driven by their own concerns and agendas. Further-

more, the broaching of certain topics could immediately "turn off" some children, making it unwise to pursue a particular topic at a predetermined point in the interview. Interviewers needed the freedom to leave a topic and return to it at a more propitious moment. For these reasons, we modified the instrument, providing the interviewer with a single sheet, listing the categories of topics to be explored and cues to the specific questions in each category. Interviewers who were familiar with all of the interview questions were thereby enabled to move flexibly from one topic to another in response to the child's thought processes and state of anxiety. We found that this interviewing method combined what seemed to be the best of both a structured and unstructured interview. Agreement among raters regarding the presence or absence of symptomatology was as high for interviews performed in this flexible fashion as it was for interviews in which questions were asked in a fixed sequence. Figure 5 is a reproduction of the summary sheet for the Bellevue Dissociative Disorders Interview for Children (BDDI-C) that was used when more systematic, sequential questioning proved impossible.

Physical and Sexual Abuse

It is ironic that, although almost every child and adolescent who suffers from DID/MPD has been severely and repeatedly maltreated, the likelihood of obtaining a history of abuse from the child is small. As stated previously, the psychiatric syndrome of DID/MPD itself comes into being to protect the child from experiencing and remembering pain. The child's shame and fear surrounding those aspects of maltreatment that he or she does recall also preclude his or her revealing them.

Nevertheless, a well-phrased, nonthreatening inquiry regarding discipline (e.g., "Have you ever made your dad go further than he meant to?") or regarding sexual experiences (e.g., "We know from television that many kids have been touched or bothered sexually. What experiences have you had?" or "Who taught you about sex?") may enable the child to provide clues to his or her abusive past. Scars on the child's body or evidence of rectal or vaginal trauma on physical examination may attest to abusive experiences that the child does not recall. Children heal rapidly, however; even the anal trauma of sodomy may be erased within 3 to 6 weeks of the event.[6] Data from medical records also are often equivocal. Most injuries receive no medical attention. When abusive parents do bring their children to doctors or emergency rooms, they attribute their children's injuries to falls and other childhood accidents.

Interviewing Alternate Personalities

Alternate personalities keep the memories that children cannot bear. Therefore a major task for the clinician is enlisting the trust of all

States of Awareness
Things feel like a dream
Spaces/daydreams/trances
Body doesn't belong to self
Out of body experience
Finds self somewhere
Deja vu
Premonition of bad thing
Feels controlled from outside

Memory
Told said or did things
Oldest memory/how far back
Loses time/events
Blamed as liar/thief
Not sure if did or just thought
Unknown people recognize patient
Found self someplace
Found clothing/drawings/writings
Flashbacks/unwanted memories

Moods
Depression
Sleep
Awakens with marks
Appetite
Suicide
Hurts self
Mania
Told/felt changeable

Imagination
TV/movie—into it
Channel switching
Special place
Special toys: real, scary
Make-believe friend
Broken toys
Talks to self
Talks to someone in head

Hearing
Earaches
Ears play tricks
Sees lips move
Hears two voices
Hear someone say bad thing
Voice telling/commenting
Baby crying
Hears mother/father

Visual/Sensory
Things/self bigger/smaller
Eyes play tricks
Watches self from outside
Makes things disappear
Feels something not there

Temper
How's temper?
Who hassles
Sets fires
Impaired memory for fights (before, during, after)
Carries weapon
Worst happened/done
Hurt someone more than thought
Worried about killing someone
Hurts animals
Who else has temper

Discipline
Parent temper/punishing
Alcohol affects mother/father
Parent goes further
How punished/worst
List of punishments
Siblings/others hurt
Ritualistic abuse
Who else?

Medical
Blocks pain
Headache/seizure/loss of consciousness
Stomach (nausea, pain)
Bowels/urine (pain, bleeding discharge)
Accidents/hospital/emergency room
Scars
Self mutilation

Sex
Who taught you
How old/far
With older/younger person
Sex for money/food/other
Who fooled around/unwanted sex
There's been a lot on TV about sex
•Within family
•Outside family
Sex with own sex
Infection from sex
Who else

Different Person
Uses different names
Called different names
Told/felt like two people
Told voice is different
Sounds like opposite sex
Told/felt possessed
Parents ever different
Parents don't remember

Skills
Suddenly unable
•Skills
•School work
Easily able
Handwriting
Signs names/tags

Figure 5. Summary sheet used to conduct an unstructured interview based on the Bellevue Dissociative Disorders Interview for Children.

personalities so that each will be willing to share what he or she knows. The astute clinician will have made the diagnosis of DID/MPD long before learning the nature and function of each and every alternate personality. Nonetheless, once the clinician knows that alternate personalities exist, personalities can be called on without actually knowing exactly who they are. That is, the examiner can ask to speak to "someone who can tell me what happened to [the patient] when he [or she] was little" or "someone who remembers how [the patient] got the scars on his back" or "the Boss" or "the person with the deep voice." The nature of a personality reflects the child's developmental stage when it was formed. Hence it is not uncommon for animal personalities to exist alongside superheroes and tiny babies. We have evaluated a 4.5-year-old boy with a tiger alternate, a 10-year-old girl with a cat alternate, a 9-year-old boy with a dog alternate, and a 4.5-year-old girl, used in pornographic films, who turned into a sexually intrusive dog.

Personalities who experienced sexual abuse or took the pain of physical torture tend to be angry and aggressive. They stood in for the child during beatings or sexual assaults. They are often proud, threatening, and contemptuous. Nevertheless, the clinician must show as much empathy for them as for innocent infantile personalities and comforting mature personalities. Any expression of criticism or reproof towards a forceful alternate personality may be perceived as a threat to his or her very existence. That personality may then attempt to retaliate and harm a weaker part of the self. This must not happen. Therefore the clinician must express compassion for all, even the most violent of alternates.

Sensitive and trustworthy clinicians may find themselves confronting alternate personalities before they feel ready to do so. The experience is somewhat like having conjured a genie from a lamp and being unable to push him back inside. Under such circumstances, the clinician must act more confident than he or she may really feel. A safe practice is always to express respect, concern, and appreciation for all personalities, known and unknown. The next step in the evaluation is to obtain a promise from all personalities that no one will hurt him- or herself or another personality. The clinician must keep in mind that one of the most potentially dangerous periods of time in the evaluation is the time when alternate personalities are first discovered. At that moment, the child's secret world has been penetrated. Strong alternate personalities usually feel exposed and betrayed by the weak child, whom they have been protecting for years and who has revealed their existence. Illogical beings that they are, unless the clinician obtains a promise of nonviolence, they are likely to make an attempt on the child's life. They do not realize that if the child dies, they too are annihilated. We have found that the most common period of time for suicide attempts or self-mutilation to occur is immediately after the clinician discovers the existence of alternate personalities. Therefore, during almost every session,

we make it a practice to express admiration and affection for all personalities and to elicit a promise that no one will hurt anyone else.

A word of caution regarding the expression of criticism by the clinician towards a real abuser. It is natural for a clinician, who learns of a parent's or caretaker's abusive treatment toward the child, to express horror and anger. This approach is unwise. It is common for the abuser himself or herself to have become one of the child's alternate personalities. When dissociative children report that they can hear their mothers or fathers shouting in their heads, they may well be hearing the voice of a powerful alternate. Therefore, criticism of a sadistic mother or violent father could elicit retaliation by that personality toward the child. Injuries that appear to be self-inflicted are often attacks by one alternate upon another.

Dealing with the multitude of different kinds of attitudes and behaviors of alternate personalities within the same child is a lesson for the clinician in tolerance and charity. One of the most common errors is for the clinician to say that some day the child will not need a particular personality. Every personality represents an aspect of the child's coping mechanisms and must be recognized as such. If personalities or identities depart or disappear, it should be in their own good time. They tend to know when the child no longer requires them for survival.

Schoolwork, Journals, and Diaries

The phenomenon of DID/MPD is hard to believe. It seems impossible for a child or an adult to switch from one identity state to another and while in one state have no knowledge or recollection of the other. To date there are no objective psychological or physiologic tests for establishing the diagnosis. One can, therefore, easily understand the skepticism of many clinicians regarding its very existence.

In most child cases, objective evidence of the illness is available for the asking. All children, from first grade onward, are required to produce written work at school. These materials are invaluable sources of documentation. A careful examination of all available written school exercises and homework papers often reveals different and distinct handwritings. For example, Figure 6 illustrates the strikingly different handwritings found among the schoolwork of a 10-year-old girl.

Many children keep journals and diaries. In the case of children with DID/MPD, different personalities make journal entries and thereby attest to their existence. Figure 7 reveals the markedly different handwritings found in the journal of an 8-year-old boy suffering from DID/MPD.

The schoolwork, journals, and diaries of children with DID/MPD often contain the names of different personalities. Names are often variations on a given name. Sometimes names of actual friends or

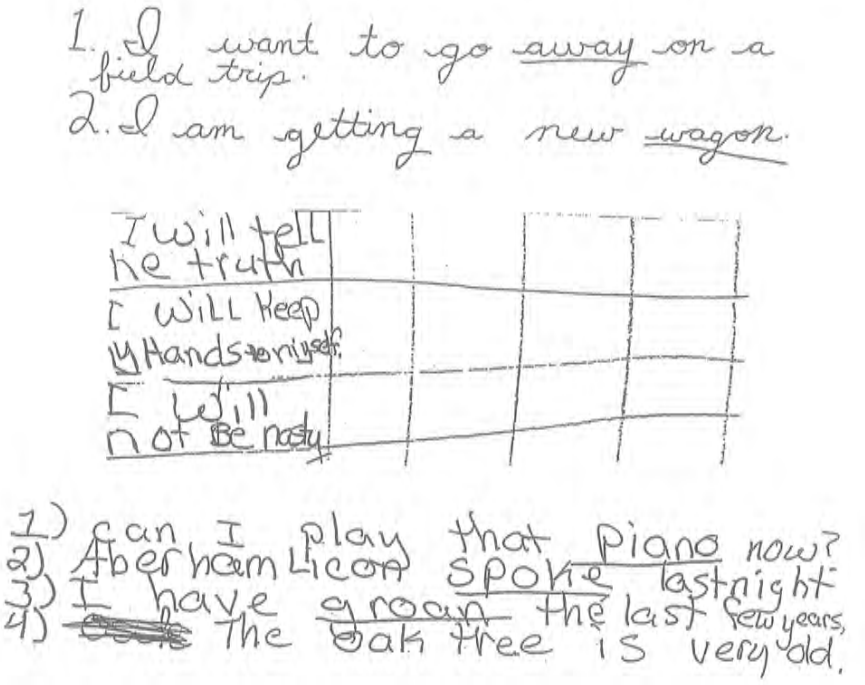

Figure 6. Examples of different handwriting styles found among school work of a 10-year-old girl with DID/MPD.

relatives are given to alternate personalities, making it hard to know to whom a child is referring. Is it the real Susan or the Susan in the child's head? Figure 8 shows four different signatures from the homework and artwork of a 12-year-old boy with DID/MPD.

We discovered that several children and adolescents whom we evaluated had written in their journals about abusive experiences that they would not discuss during our evaluation. Children and adolescents with DID/MPD often have drawn pictures of what has happened to them, and these can sometimes be found in their notebooks and journals. Figure 9 was found in the school notebook of an 8-year-old boy with DID/MPD.

The drawings in Figure 10 were discovered among the doodles in sketchbooks belonging to an adolescent girl with DID/MPD. Note the four intertwined bodies in various sexually explicit positions in Figure 10*A*.

Different personalities also may have very different artistic styles. Note the very different styles of the two obscene pictures in Figure 10*B*.

The writings and drawings illustrated are graphic evidence of DID/

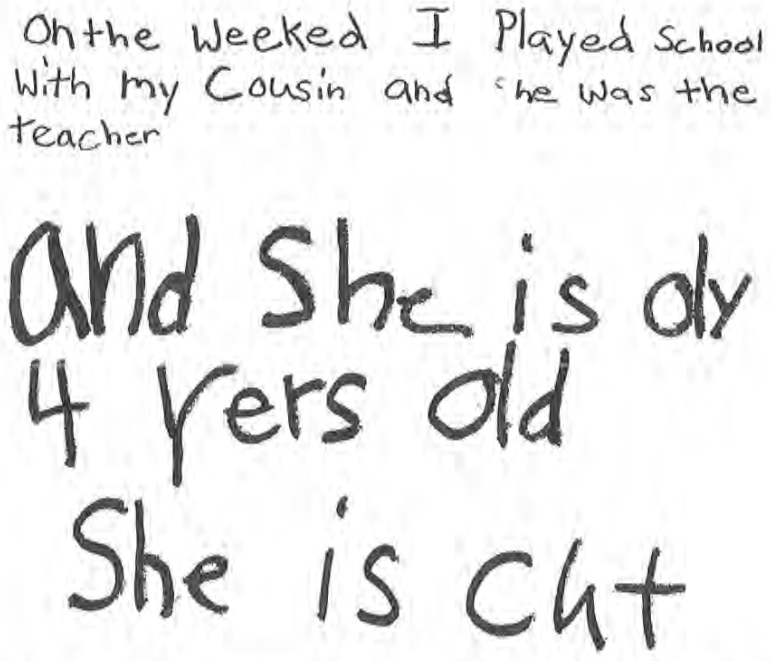

Figure 7. Examples of different handwriting styles found in the journal of an 8-year-old boy with DID/MPD.

MPD. They are especially convincing because they were produced outside of evaluation sessions, prior to diagnosis, and therefore could not have been influenced by the clinician performing the evaluation.

DIFFERENTIAL DIAGNOSIS

Table 1 lists the most common psychiatric and neurologic conditions with which DID/MPD is confused in children, along with their symptoms. They include attention-deficit hyperactivity disorder, bipolar and unipolar mood disorders, schizophrenia, seizures, borderline states, and conduct disorder. Given the numerous symptoms and signs that are shared with these other conditions by DID/MPD, how does one begin to distinguish DID/MPD from them?

To begin with, the very number and variety of signs, symptoms, and behaviors characteristic of DID/MPD distinguish it from most other conditions. Although the child may have just about every symptom

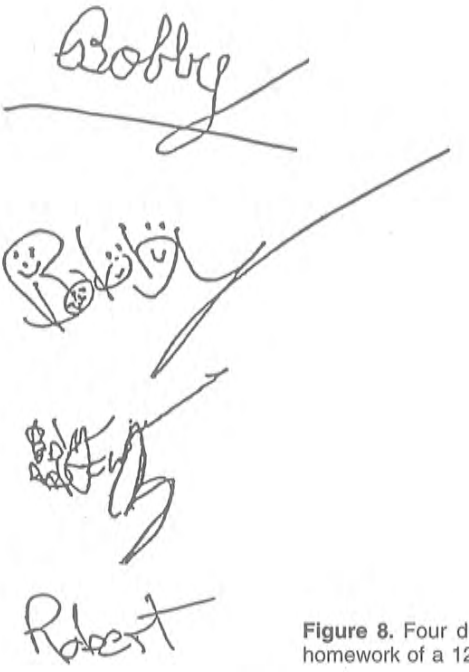

Figure 8. Four different signatures found on artwork and homework of a 12-year-old boy with DID/MPD.

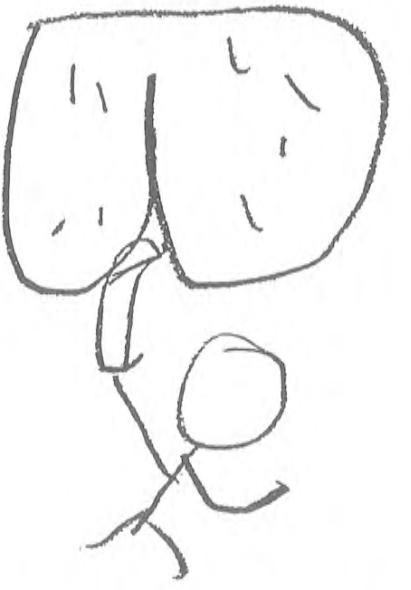

Figure 9. Drawing found in a school notebook of a sexually abused 8-year-old boy with DID/MPD.

Figure 10. *A* and *B*, Drawings found in sketchbooks of a 17-year-old girl with DID/MPD.

listed for a particular diagnosis, the child also suffers from additional symptoms that would excluded him or her from that diagnosis. A few examples follow.

A child's inattention, distractibility, emotional lability, fluctuating skills, and poor memory might justify a diagnosis of attention-deficit hyperactivity disorder. The child's auditory hallucinations, trances, and

peculiar circumscribed periods of amnesia, however, would call into question that diagnosis. Furthermore, although dissociative children may have brief positive responses to treatment with stimulant medication, these effects tend to be short lived.

A child's command hallucinations, delusional beliefs, blocking, and illogical thought processes would seem consistent with a diagnosis of schizophrenia. However, the child's overall warmth and relatedness, wide range of affect, and other symptoms (e.g., amnesias, trances) would call such a diagnosis into question. Furthermore, the auditory hallucinations experienced by children with DID/MPD do not respond to antipsychotic medication.

A child's dangerous, aggressive, sexual, and runaway behaviors and his or her tendency to deny responsibility (e.g., lie, steal) would seem to qualify the child for a diagnosis of conduct disorder. Again, however, the child's auditory hallucinations, peculiar beliefs, trances, and changeable demeanor would preclude so simplistic a diagnosis.

The trances, amnesias, falling episodes, and sleep attacks of some children with DID/MPD invite a diagnosis of seizures. A normal electroencephalogram, even several normal electroencephalograms, would not necessarily rule out a true seizure disorder. Complex partial seizures are often best diagnosed clinically. Even the child's psychotic symptoms could be interictal phenomena. The response of the child's seizure-like symptoms to suggestion (e.g., "When the voices quiet down and I count to three you will stop shaking and wake up"), the histrionic quality of the apparent seizures, and their failure to respond to anti-epileptic medication, however, distinguish the condition from a physiologically caused seizure disorder.

Children with DID/MPD often exhibit strikingly intense and labile moods and thus may appear to suffer from a unipolar or bipolar mood disorder. The switches from one mood to another, however, are often instantaneous and dramatic, whereas in a bipolar mood disorder moods usually last longer, and changes from one feeling state to another are more gradual. Sometimes the child's weepiness or elation can be recognized as occurring only when the child is in specific identity states (e.g., a crying baby, a grandiose adult). Children with mood disorders who do not dissociate have a greater continuity of personality despite their mood changes. They also do not have the trances and amnesias associated with DID/MPD.

A word should be said regarding the appropriateness of making a diagnosis of borderline personality in children or adolescents. Certainly the moodswings, impulsiveness, somatic complaints, unstable relationships, self-mutilation, and episodic psychotic symptoms that one sees in DID/MPD would seem to qualify certain children and adolescents (as well as adults) for a diagnosis of borderline personality. The remarkable similarities between the symptoms considered to be those of borderline states and the symptoms of DID/MPD raise the question whether many,

if not most, children and adults who present with this very mixed picture of symptoms and behaviors and who are called borderline really suffer from dissociative disorders of differing intensities.

SUMMARY AND CONCLUSION

Hallucinations, delusions, attentional deficits, restlessness, learning difficulties, behavioral problems, lying, stealing, somatic complaints, seizure-like states—all of these characteristics and more can be found in children with DID/MPD, yet no one of these characteristics, and in fact no specific combination of them, is pathognomonic of the disorder. The clinician must look beneath this mishmash of different signs, symptoms, and behaviors to uncover the three basic underlying psychological phenomena from which the rest of the symptomatology of DID/MPD derives: trance states, amnesias, and the tendency to switch from one identity or awareness state to another.

No single article can discuss all of the characteristics of so complex a phenomenon as DID/MPD in children, nor can it include all of the techniques for recognizing them. This article simply provides a map and flashlight with which to see the lay of the land, and some tools with which to begin digging.

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