State intervention and childhood multiple personality disorder

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Multiple personality disorder is a mental disorder caused, in part, by childhood trauma, most usually severe and sustained physical, sexual, and emotional abuse. Although the disorder is usually diagnosed in adults, evidence shows that it develops during childhood, with the first personality split typically occurring before the age of eight. Using a criterion of harm, this article argues that the diagnosis of multiple personality in a child ought serve as prima facie evidence for child abuse, even if compelling physical evidence is lacking. Medical, social, and legal problems raised by the diagnosis of childhood multiple personality disorder are discussed.

Child abuse spotlights the problems of the state's attempt to strike a balance between protection of children and recognition of the family as an autonomous unit. Because of children's vulnerability, the state has provided legislation over the past 100 years designed to keep children from being harmed by their caretakers. Because of the liberty and privacy implied by the recognition of an autonomous family unit, the state has been reluctant to impose state standards or expectations for family process. Mistakes have been made in attempting to strike this balance. Children have been

> The childhoods of most of these patients, like those of almost all previously reported cases of multiple personality, were characterized by severe family discord or instability or by obvious psychopathology in one or both parents [citations omitted]. Virtually all of these patients, like many of those cited by Greaves, experienced severe psychic or physical abuse and/or sexual trauma during early childhood [citations omitted].[5]

The high correlation between child abuse and the diagnosis of MPD in adults continues to be reported. According to Frank W. Putnam, M.D., Staff Psychiatrist, Biological Psychiatry Branch, National Institutes of Mental Health, who is conducting a series of studies on MPD as well as maintaining a national data bank for case reporting, 80% of the patients included in his data bank report a history of physical abuse and 79% (obviously, with some overlap) report a history of sexual abuse. The significance of these figures, which Putnam terms as "still a little low," is more telling when one considers that "3–4% of all psychiatric patients report a history of child abuse."[6] In fact, according to Putnam, these data, "together with numerous clinical observations suggest that MPD is in fact a psychiatric disorder that has a relatively specific precipitant, incestuous sexual abuse, and begins in childhood."[7]

Roberta Sachs, Ph.D., a Chicago psychologist who has seen 20–25 multiples in consultation or treatment, believes that the number of multiple personality patients who were sexually or physically abused as children comprises a "high 90 percentile" of the cases. Every patient she has seen, Sachs believes, was abused.[8]

Cornelia Wilbur, M.D., a recognized expert on MPD and therapist to Sybil, perhaps the most famous multiple, unalterably states, "Yes! MP is evidence of child abuse."[9] David Caul, M.D., Medical Director of Athens Mental Health Center, who has treated or consulted with 26 multiples, agrees. "The diagnosis of multiple personality serves as

"compelling" evidence of child abuse to me and almost all clinicians who treat multiples."[10]

Although Richard Kluft, M.D., a Philadelphia-based psychiatrist who has seen 149 MPD patients, warns against making child abuse synonymous with the "overwhelming of the child's adaptive capacities," which he cites as one of the four necessary factors for development of the disorder, Kluft agrees that the majority of identified patients have been abused—"the vast majority are." In listing other possible sorts of overwhelming trauma, "the terrible pain associated with childhood illness . . . war . . . object loss," Kluft states that there would be a "high index of suspicion" of child abuse as a causal factor in the absence of other trauma.[11]

As the disorder almost invariably develops through causal factors in childhood, it is not surprising that the first splits in the personality occur in childhood as well. On the basis of analysis of three clinicians' cases, totaling 66 patients, Putnam found that:

> Dr. Allison's data suggests that in 80% of his cases the dissociative split occurred by age 10. Putnam found the mean age of the first personality dissociation as 7.1 years. Dr. Bliss found the highest incidence of first dissociation occurring at about 5 years. . . .[12]

Putnam's analysis is consistent with Greaves' review that, "Alter selves usually first manifest themselves in early childhood, as early as age 2½, and typically by age 6 or 8.[13] While Putnam states that it is difficult (though not impossible) to diagnose the disorder in a child under 12, the fact that most first splits occur before the age of 10 makes this very much a "childhood disorder."[14]

It is also not surprising, as more professional focus is turned to the disorder in adults, that more professional notice is being given to the disorder in children. Certainly this is not

exemplified by review of clinical literature, as there has not been a case of childhood MPD written up as such since 1811.[15] However, clinicians most knowledgeable of the disorder are having children with MPD brought to their attention. Sachs has seen three cases of childhood MPD, Putnam has seen six, Caul has consulted on two, and Kluft has seen four or five and has consulted on a couple dozen more (including teenaged multiples), based on cursory polling of these clinicians alone. Greaves observes that, based on the "rash of new cases" of MPD reported recently,

> . . . one may surmise that there are scores, possibly hundreds, of persons suffering at any given time from this painful, puzzling, and often disabling personality condition, and who, as either undiagnosed or misdiagnosed, are failing to reap the benefits of appropriate treatment.[16]

It is reasonable to assume that there are many more childhood multiples in existence than these figures show. As the disorder becomes more widely known through professional and popular literature, it is also safe to assume that more undiagnosed childhood multiples will be recognized.

While it seems clear, because of the abusive factor, that the identification of a childhood multiple should demand immediate action on the part of the state, it is also understandable why the state would be hesitant to intervene in such a case. First, a problem which can only be solved by more public education and experience with multiple children is that the disorder is not well known or understood in professional circles—among lawyers, judges, protective-service case workers, and even among many mental health professionals. Lacking precedent and information about the condition, it is likely that professionals will not respond appropriately, even when presented with an obvious case of a child suffering from the disorder.

The criterion which is currently used for state intervention—obvious physical harm which cannot reasonably be ex-

plained in any way except by parental maltreatment—will not suffice. While childhood multiples usually have long histories of physical and sexual abuse, obvious signs of assault may not exist. The sexual-abusing parent may stop short of actual penetration or may not cause the sort of blatant genital trauma which might be noticed. While tying the child up for long periods of time or locking the child in drawers, toychests, and closets would undeniably be classified as abuse, the signs of such abuse may be the splintering of the child's personality rather than broken bones or bruises.

In addition, the childhood multiple is even less likely to detail the abuse for a professional than is the normally reluctant child. Because of the splits in the personality, the personality presenting for the professional interview may well be amnesiac of the instances of abuse. It is not unlikely that the child will remember only loving moments with the abusing parent(s).

Yet, despite the hidden nature of the abuse, the symptoms of MPD may be recognized by any person who understands the disorder, particularly in an older child.[17] This may cause a problem for those professionals who know the disorder, see signs of it in a child, and who are under mandate to report suspected child abuse.

"Because identification of abused and neglected children is necessary before anything may be done to help them, all states require the reporting of suspected maltreatment."[18] The recognition of a child multiple raises, at the very least, an index of suspicion that abuse has occurred. If the person recognizing signs of the disorder is a physician or, in many states, a nurse, schoolteacher or official, police officer, social worker or day-care worker, that person is legally required to report if there is reasonable cause to suspect abuse. It seems clear that the existence of the disorder in a child constitutes reasonable cause to suspect abuse. If the

protective-services case worker assigned to make the final determination of abuse is not knowledgeable of the disorder, it is unlikely that the case worker will make this determination based on interview, observation of parent–child interaction, condition of the home, or by looking for correlating physical data. The lack of precedent for these sorts of cases raises more difficulties. And, although all states provide for criminal and/or civil penalties for failure to report, and civil suits may be filed for damage incurred by the child for failure to report,[19] it is fair to ask what difference this reporting will make. It is fair to ask if the report with no reasonable hope of adequate state response will do more harm than good.

While it is safe to assume that those professionals working with child multiples have not sought state intervention, at least not citing MPD as the basis for complaint, state intervention is theoretically justifiable in a case of childhood MPD.

Because of the state's inability, in such a pluralistic society, to set standards for adequate parenting, the deciding criterion for child abuse must be a utilitarian view of the consequences of parental action—the state investigates if there is good reason to suspect that the child has been harmed and coercively intervenes if the harm is undeniable. If no other trauma can be discovered in the multiple child's life, even if compelling physical evidence of child abuse is absent, the fact remains that the child is suffering from a debilitating mental disorder which no published report has suggested to rest solely on genetic factors or factors internal to the child's mind. The end result is a disturbed child, as clearly as the end result of other, more blatant child abuse may be broken bones. It is consistent that the state's criterion of harmful abuse be used to allow intervention in cases of childhood MPD. As Natalie Abrams correctly infers from such current utilitarian definitions, "if harmful effects . . .

are taken to justify state intervention, then the child's condition is the significant factor, regardless of how or by whom the harm was caused."[20]

Despite Goldstein, Freud, and Solnit's rejection of emotional harm as "too vague and imprecise to justify coercive intrusion,"[21] they too might be willing to accept state intervention in cases of identified child multiples because of the connection of the disorder with environmental factors. These authors disagree with state intervention with emotionally disturbed children because,

> . . . there can be no . . . certainty that the attitudes or the action or inaction of the parents cause these damaging symptoms in the same way that we can be certain of the origins of physical abuse. A child can become emotionally disturbed in response to parental attitudes, to fateful events, to a combination of these, or entirely because of internal or inborn factors.[22]

The correlation between child abuse and MPD is too high to include the disorder in the Goldstein et al. explanation of emotional disturbance. While child abuse alone is not viewed as a necessary and sufficient condition to the development of the disorder—clinicians cite a particular sensitivity in the child, a high degree of hypnotizability, and a lack of perceived or real support in the environment as also necessary conditions—blaming the child's sensitivity and suggestibility for the development of the disorder would be equivalent to blaming another child's particularly demanding nature for his physical battering. Admittedly, there is a circumstantial element in believing, unless proven otherwise, that child abuse is a causal factor in a particular child's development of MPD. When there are no witnesses, the same circumstantial element is present in deciding that caretakers caused another child's unexplained injuries or death. Using a criterion of harm, consistently with how it is used in other child abuse cases, childhood MPD ought qualify as the necessary evidence for state investigation and intervention.

Just what that state intervention ought be is not clear. Goldstein et al. suggest that the state permanently remove a physically battered child from the home because,

> Parental maltreatment leaves psychological scars which endure long beyond any physical healing and preclude a child from regaining the feeling of being safe, wanted, and cared for in his parents' presence—the very emotions on which his further developmental advances need to be based.[23]

Based on these authors' criterion of the child's feeling of safety, it may well be the case that the child multiple should not be allowed to remain or return to the home which helped cause the child's personality to shatter.

It may be that the child multiple ought to be removed from the home at once, as some clinicians believe, and placed in a special environment with foster or group parents who can serve as adjunct to the child's therapist.[24] Obviously, such environments are now nonexistent and in attempting currently to remove the child multiple from the home, one certainly "would play hell getting this done by the typical Children's Services in most communities," as Caul states.[25] Because of the lack of adequate alternatives, some combination of individual and family therapy may be the only realistic alternative open to therapists, even if it is not the treatment of choice. However, the clinician may need the backing of the state to accomplish even this much or to reach the children requiring assistance.

As the difficulties expressed in this discussion are more speculative than substantive, one might legitimately question the efficacy of this sort of speculation. It is important to consider implications of the identification of childhood MPD before the state and clinicians find the problem thrust upon them by actual cases. Because of increased attention on the disorder, the potential problems may well become actualities soon.

The growth in clinical literature on MPD has already been discussed. Since the May 1982 Boor review, more case write-ups and discussion have been published; others are in press or are in progress. More attention on MPD is currently being brought in the popular press as well. *Psychology Today* ran a short piece on Putnam's research in its October 1982 issue. *Time Magazine* included a write-up on an adult multiple in treatment in the October 25, 1982 issue, which was followed up the next week by an interview with the multiple's therapist and Wilbur on "Good Morning, America."

Ellen Hale, a journalist for Gannett News Service, sent a detailed four-part series on MPD over the Gannett wire in November 1982, which has so far run in more than half of the 89 newspapers subscribing to the service. Hale says, "A lot of them gave it really prominent play, including running it on the front page."[26] An article for *The New York Times Sunday Magazine* by the same writer appeared in the April 17, 1983 edition. While Hale's articles deal with the disorder in adults, the correlation to child abuse is made by the clinicians interviewed.

It is unquestionable that more child multiples will be recognized through public and professional exposure to the disorder; it is likely that more will be identified as such by knowledgeable professionals.

Identification of an uncommonality of any sort implies special claims on the part of the identified person. Once an uncommonality is recognized, just treatment of the individual consists of more than meeting the minimum claims of persons not specially identified. For example, a school district which identifies children as learning disabled, mentally retarded, physically handicapped, or even as gifted sets those children apart from the norm in some relevant way and obliges itself to meet some moral claim on the part of

the individuals identified. The extent of the claim and the amount of obligation on a particular agent may vary, of course. A parent who recognizes a particular talent in one of her children may be under slight or no moral obligation to develop that talent at the expense of meeting her other children's needs. A school district, on the other hand, which develops and/or utilizes an objective criterion to identify children with an uncommon characteristic incurs a moral obligation to respond to that identification. This response may be as small as providing notification to the child's parents that the child may have a visual problem or as great as providing alternative or adjunct learning environments for children with an educationally related deviation. It is reasonable to believe that the sole purpose of a screening process which would result in identification is the district's recognition of a special claim among those to be identified. Screening without this recognition consists of professional voyeurism at the expense of the child who is labeled as uncommon without that uncommonality being addressed. The state has also recognized the morality of classes of individuals with special claims and has developed various suspect classifications for deciding the extent of obligation on the part of the state to meet those claims.

Special situations and special individuals exist without external identification of uncommonality. However, such identification ought not take place without accompanying recognition of the special claim implied.

What, then, is implied by the identification of a child multiple? A reasonable implication seems to be that the identifying agent assumes some obligation to recognize the child's special claim. This special claim may differ from case to case, as might the extent of obligation on the identifying agent. The minimum obligation on the part of any person who identifies the child as multiple, and who thus has reasonable cause to suspect that the child has been abused,

should include recognition of whatever special claims to state protection are legally provided to every abused child. Because of the high degree of probability of accompanying child abuse and the state's interest in protecting abused children, it is reasonable to expect the state to cooperate by educating protective-service case workers and judiciary personnel about the disorder. It is reasonable to expect the state to investigate cases of childhood MPD brought to its attention, and to make decisions on appropriate intervention regardless of the lack of compelling physical evidence of child abuse. The state must be willing to work with knowledgeable clinicians to decide what sort of intervention is truly in the child's best interest and clinicians must be willing to help educate protective-service case workers, lawyers, and judges if there is to be any legal support of clinicians who are trying to meet the needs of these children.

If the state is not willing to intervene appropriately in cases of childhood MPD, it is questionable as to whether identification of such children ought be made at all. If the identifying agent is, as is likely, a knowledgeable clinician, the ability to meet the special claim of such an identified child needs to be considered. It is reasonable to expect that a clinician would identify the child as a multiple with the desire to treat the child or to refer the child to another clinician for treatment of the disorder. This treatment most commonly involves therapeutic removal of disassociation as a coping mechanism and integration of the various personalities. Without intervention into the environment which is most usually a causal factor of the disorder, it is appropriate to ask if it is possible, and then ethical, to strip a child of the defense which makes survival in the environment possible.

This discussion has attempted to justify state intervention in cases of childhood multiple personality disorder. Such intervention as suggested will meet with resistance by those favoring more weight on the side of family autonomy. It is

undeniable that some families will be the targets of unwarranted intrusion, in particular, those few families where the trauma triggering the disorder is not abuse. Because of the extremely high incidence of abuse in cases of MPD, the burden of proof will be on the child's caretakers to explain what other trauma may have served as a causal factor in the development of the disorder. The unwarranted intrusion into a few families where the caretakers must puzzle out what "overwhelming of the child's adaptive capacities" has taken place may constitute less mistreatment by the state than that constituted by the state's ignorance of the disorder, which has allowed at least hundreds of children to remain in homes where the triggering trauma was very definitely child abuse.[27]

Notes

1. Marjorie R. Freiman, "Unequal and Inadequate Protection Under the Law: State Child Abuse Statutes," *The George Washington Law Review,* January 1982, vol. 50, no. 2, p. 259.

2. Myron Boor, "The Multiple Personality Epidemic, Additional Cases and Inferences Regarding Diagnosis, Etiology, Dynamics, and Treatment," *The Journal of Nervous and Mental Disease,* May 1982, vol. 170, no. 5, p. 302.

3. A. Ludwig et al., "The Objective Study of Multiple Personality, or Are Four Heads Better Than One?," *Arch. Gen. Psychiatry,* 1972, vol. 26, pp. 298-99, cited by George B. Greaves, "Multiple Personality, 165 Years After Mary Reynolds," *The Journal of Nervous and Mental Disease,* October 1980, vol. 168, no. 10, p. 581.

4. Greaves, *supra* note 3, at 594.

5. Boor, *supra* note 2, at 303.

6. Frank W. Putnam, telephone interview, November 1982.

7. Frank W. Putnam, "Child MPD Proposal" (Presented to Prince Georges Country, Maryland, Hospital Board in June 1981 and to Montgomery County, Maryland, Protective Services in February 1981).

8. Roberta Sachs, telephone interview, November 1982.

9. Cornelia B. Wilbur, personal letter, October 21, 1982.

10. David Caul, personal letter, November 3, 1982.

11. Richard Kluft, telephone interview, November 1982.

12. Putnam, *supra* note 7.

13. Greaves, *supra* note 3, at 587.

14. Putnam, *supra* note 6.

15. Kluft, *supra* note 11.

16. Greaves, *supra* note 3, at 578.

17. Putnam provides the following proposed childhood MPD predictors in his "Child MPD Proposal": "1. Children who have received sustained, repeated sexual or physical abuse. 2. Children who are amnestic for the sexual or physical abuse. 3. Children who are self-mutilators. 4. Children who report auditory hallucinations. 5. Children who demonstrate rapid regressions in behavior or who show marked variations in age-appropriate behavior. 6. Children who report conversations with imaginary playmates beyond the age of six. 7. Children who show marked day-to-day or hour-to-hour variations in their abilities, *e.g.*, reading, playing games, doing arithmetic, different vocabularies or comprehension. 8. Children who report amnesia or loss of time or who deny participating in events where it is known that they did in fact participate. 9. Children who deny obvious behavior or attribute it to an 'imaginary playmate.' 10. Children with frequent sleepwalking. 11. Children with 'hysterical' physical symptoms, *e.g.*, blindness, paralysis, 'convulsions.' 12. Children with rapidly fluctuating physical complaints. 13. Children who refer to themselves in the third person." Putnam adds, "The spectrum of behaviors described above is probably shared to a greater or lesser extent by children who do not have MPD. The differentiation of children with MPD will require an interview or series of interviews by a trained professional familiar with the MPD syndrome."

18. Freiman, *supra* note 1, at 253.

19. *Id.* at 261.

20. Natalie Abrams, "Problems in Defining Child Abuse and Neglect," in *Having Children*, ed. Onora O'Neill and William Ruddick (New York: Oxford University Press, 1979), p. 159.

21. Joseph Goldstein, Anna Freud, and Albert J. Solnit, *Before the Best Interests of the Child* (New York: The Free Press, 1979), p. 72.

22. *Id.* at 76-77.

23. *Id.* at 73.

24. In fact, one of the "problems" Putnam cites (*supra* note 6) in the diagnosis of the disorder in children is that "once the child is taken out of the situation, they [*sic*] stop disassociating." It may be that, for a child who has not established a many-year pattern of disassociating, a move to a healthy environment may in itself effect a cure.

25. Caul, *supra* note 10.

26. Ellen Hale, telephone interview, December 10, 1982.

27. It must be noted that this simplistic, theoretical treatment of MPD in relation to state intervention practices ignores some very real practicalities of the current situation. I am grateful to Sachs and Putnam for pointing out to me that lack of state and federal funding makes protective service organizations currently ineffectual to complete even minimal investigations of the most blatant cases of child abuse. The economic situation most likely constitutes a far greater barrier to protection of abused children than does respect for a model of family autonomy. The economic situation is obviously beyond the scope of this discussion, as is the question raised by the situation: If the state is not willing to adequately fund protective service organizations, can the state really be said to have an interest in protecting children?