

# SYSTEMATIC ASSESSMENT OF DISSOCIATIVE IDENTITY DISORDER IN AN ADOLESCENT WHO IS BLIND

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## ABSTRACT

*Although the connection between abuse in childhood and later development of multiple personality disorder is increasingly well-documented, few studies exist of dissociative identity disorder (DID) patients drawn from a subpopulation at high risk for child abuse, namely individuals with disabilities. This paper presents the diagnostic assessment of DID in an adolescent who is blind, using the Structural Clinical Interview for DSM-IV Dissociative Disorders (SCID-D), an extensively field-tested semi-structured interview for the detection of dissociative symptoms and disorders. The case study includes a description and analysis of the patient's SCID-D interview and its findings, with emphasis on the similarity of the patient's symptoms to those reported by adult patients without disabilities who suffer from DID. The article concludes with remarks about the need for further research regarding the prevalence of dissociative disorders in a) the adolescent population; and b) the population of individuals with physical or developmental disabilities. In addition, new studies utilizing the SCID-D should facilitate systematic investigation of dissociative symptoms and disorders in the adolescent population.*

## INTRODUCTION

Dissociative identity disorder (DID) is described in *DSM-IV* as the existence of two or more distinct identities that assume control of a person's behavior and thought. It is the most severe of the dissociative disorders (syndromes involving disturbance in the integrative functions of memory, identity or consciousness (American Psychiatric Association, 1994).

DID develops in response to severe recurrent childhood trauma, including (but not restricted to) emotional, physical, and/or sexual abuse (Chu & Dill, 1990; Fine, 1990; Frischholz, 1985; Kluft, 1985a; Kluft, 1990a; Putnam, 1985; Spiegel, 1991; Wilbur, 1984a). In the past ten years, studies have estimated the prevalence of DID to range from 1%-10% of the psychiatric population (Bliss & Jeppsen, 1985; Kluft, 1991; Putnam, Guroff, Silberman, Barban, & Post., 1986; Ross, Norton & Wozney, 1989). Misdiagnosis of DID is a frequent occurrence, due to diagnostic confusion with other psychiatric disorders, including mood, psychotic, anxiety, substance abuse, eating and personality disorders (Coons, 1984; Kluft, 1991; Putnam et al., 1986; Rosenbaum, 1980; Ross & Norton, 1988; Steinberg, in press; Torem, 1986). Patients with DID spend an average of 6.8 to seven years in therapy before receiving the correct diagnosis and implementation of appropriate treatment (Coons, Bowman, & Milstein, 1988; Putnam et al., 1986).

Children with learning problems, physical handicaps, or chronic illnesses may be at increased risk of abuse or neglect due to the increased emotional and financial stress on the parents, their own non-compliance and acting out, their physical dependence on caretakers, and their frequent residence in institutional settings (Fontana, 1992; Garbarino, Guttman, & Seeley, 1986; Sullivan, Brookhausen, Scanton, Knutson, & Schulte, 1991; Whittaker, 1987). Abuse and neglect are common sources of physical and psychological injury to disabled individuals; rates of prevalence have been estimated as high as 50% (Ammerman, Van Hasselt, Hersen, McGonigle, et al., 1989; Sullivan et al., 1991). Deaf children have been found to have rates of 24% for physical abuse and up to 50% for sexual abuse (Sullivan, Scanlan, & LaBarre, 1986; Sullivan, Vernon, & Scanlan, 1987). Equally high rates of abuse have also been noted for the blind (Elonen & Swarensteyn, 1975). Few studies, however, have investigated the incidence of abuse among individuals who are blind or deaf.

Given this increased risk of trauma, individuals with disabilities are subsequently at increased risk of developing dissociative symptoms and disorders. To begin with, the loss or absence of one or more of the bodily senses is itself a factor in the construction of dissociative defenses; previous studies have noted the development of dissociative symptoms in response to sensory deprivation (Reed & Sedman, 1964; Roberts, 1960; Trueman, 1984b). Other factors which place disabled children at higher risk of abuse include impaired

communication skills, separation from the protection of the home, and conditioned compliance with authority figures (Sullivan et al., 1991; Sullivan, Vernon, & Scanlan, 1987).

It is also likely that misdiagnosis of individuals with physical handicaps and disabilities who have suffered abuse is even more prevalent because of this population's greater dependence on caretakers, the difficulty of separating them from "known and trusted" abusers, and the unwillingness of schools and institutions to take full responsibility for incidents of abuse (Sullivan et al., 1991; Sullivan, Vernon, & Scanlan, 1987). Specific interviewing strategies are therefore essential in order to identify the presence and severity of dissociative disorders among individuals with disabilities.

The recent development of effective screening (Bernstein & Putnam, 1986; Riley, 1988; Sanders, 1986) and diagnostic tools has improved the accuracy of detection of this group of disorders (Ross, et al., 1989; Steinberg, 1994a). The *Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)* (Steinberg, 1994a) is particularly useful to clinicians because it systematically assesses the severity as well as the presence of post-traumatic dissociative symptoms and disorders in patients with all psychiatric disorders. Until this time, there have been no reports of the use of diagnostic interviews in the detection of dissociative disorders in adolescents.

To date, there have been few reports published concerning dissociative symptoms in patients with disabilities. One published case study involved a pre-lingually deaf patient with dissociative identity disorder (DID) (Bowman & Coons, 1990). Cases of DID have also been reported in sighted individuals in which one or more alter personalities were blind or deaf (Wall, 1991). In addition, the existence of DID in individuals with developmental disabilities has also been described in the literature (Lindsley, 1989). However, to date, no case studies have been reported of individuals with multiple personality disorder who are blind.

The present case report discusses a patient who is blind and has been diagnosed with DID, using the *Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)* (Steinberg, 1993b). We will describe the systematic assessment of the five dissociative symptoms leading to the diagnosis of a dissociative disorder, as evaluated by the *SCID-D*. Diagnostic and treatment implications of this case study will be discussed.

### ***Instrument: The Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)***

The *SCID-D* is a semi-structured clinical interview that comprehensively evaluates the presence and severity of 5 core dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration; and diagnoses the dissociative disorders, based on *DSM-IV* diagnostic criteria. The *SCID-D* has been extensively field-tested in over 500 patients, and several investigators have reported good-to-excellent reliability and validity for its detection and assessment of dissociative symptoms and disorders (Boon & Draijer, 1991; Goff, Olin, Jenike, Paer, & Buttolph, 1992; Steinberg, Cicchetti, Buchanan, Hall, & Rounsaville, 1989-1992; Steinberg et al., 1989-1993; Steinberg, Rounsaville, & Cicchetti, 1990). The *Interviewer's Guide to the SCID-D*

(Steinberg, 1994b) provides guidelines for the administration, scoring and interpretation of the *SCID-D*. The Severity Rating Definitions, described in the *Interviewer's Guide*, provide operationalized criteria for evaluating and rating the severity of each of the five dissociative symptoms.

### **CASE STUDY**

Melissa is an 18-year-old Caucasian female who has been in treatment for one year with one of the authors (A.S.), who practices supportive-expressive and psychodynamic psychotherapy. Melissa is congenitally blind and attends a residential school for the blind in a large Eastern metropolitan area. During her first year of treatment, she was active in student activities and competitive sports, including swimming and goal ball (a team sport similar to soccer, but with an auditory stimulus for students who are blind).

Melissa was referred for treatment by her school counselor for the evaluation of her report of internal experiences of being strangled and smothered, as well as intermittent feelings of being struck or raped. She reported olfactory sensations as well, but could not identify the smells more precisely. She reported occasionally hearing moans and cries. The most pervasive and overwhelming sensory experiences occurred when she was in the shower; during such moments, she reported feeling shaky, flushed and fearful.

The etiology of Melissa's blindness was retrolental fibroplasia, bilateral congenital cataracts, and detached retinas. She had a history of pulmonary insufficiency of prematurity, and a several-year history of ringing tinnitus and intermittent balance difficulties. Her intractable tinnitus had created difficulties with mobility (e.g., in street crossings) and independent living skills.

### **COURSE OF THERAPY**

After the initiation of therapy, Melissa announced that she would not return home during the school holidays because her feelings of being strangled, smothered and thrown across the room were particularly severe in the home setting. She began to report being teased and taunted about her blindness by her brother and other family members. Because crying as a response to pain was not tolerated in the home setting, Melissa stated that she never cried when frightened or hurt.

In spite of her misgivings, Melissa did return home for a holiday break, and reported that she experienced feelings of being choked, hit on the head with a brick, punched in the back, and being chased. She also reported smelling blood, and felt that someone had taken a knife to her throat in the shower. Despite these unsettling experiences, Melissa's performance in school was outstanding, and her general level of functioning exemplary. After this visit, she began to explore past interactions with her mother with the therapist: "When I think I am going to get hit, my Mom says, 'What's the matter, you think I'm gonna hit you?' I guess my face shows it." The experience of being struck, without visual warning, elicited an anticipatory "freeze" response when the patient sensed

an impending slap or punch, which she demonstrated for the therapist. By contrast, Melissa described her first experiences in the residential school as surprisingly pleasant. "I remember when I started school, I couldn't believe how nice people could be! I guess I have never known anyone else like my Mom." She remarked that "if you were to observe me at home and at school, it is really like two different people..." She acknowledged the existential pain of her experience of family life: "If there are any other teenagers dealing with this, I just don't think that they would be alive anymore..."

Due to a scheduling mishap, Melissa came unaccompanied to the waiting room and awaited the therapist's arrival for one hour. After the session began, it became clear that she was angry about the unexpected delay, and enacted what appeared to be a personal drama involving several characters. The patient utilized three different voices, each with its own distinct intonation and accent. She reported that when bored or angry, she would construct and play out a script in her head, or assign a friend to participate in the enactment.

Melissa's history of traumatic events continued to unfold. She recalled that when she cried (as a child), a hand would be placed over her mouth and she would be admonished to stop crying, with the additional warning, "or I'll give you something to cry about." Her punishments included standing in a corner for extended periods of time, and being struck by her mother. She remembered an episode in which hot grease was "splashed on me accidentally." In recent years, the most dreaded event of each visit home was a ritual weighing, accompanied by verbal scolding for any weight gain, with resultant deep humiliation. During home visits, Melissa was also restricted from visiting her father, who lived a short distance from her mother's home. Given this combination of humiliations and prohibitions, Melissa compared going home to being imprisoned.

Three months into treatment, Melissa began to describe experiences of identity confusion. She opened one session by remarking, "I don't know who I am. There is one part that's good, another that's bad. All together, I think there are 4 or 5 parts." During the same session, she recalled past bed-wetting experiences and their consequences: "If I wet the bed, [my mother] 'd do, like what you do with a dog — she'd rub my nose in it and then she'd put me in a cold shower." Melissa then observed, "This might have been one of those memories that was there all the time. Come to think of it, maybe that's why I get weird feelings in the shower sometimes." She recalled her earlier use of dolls and an imaginary friend for self-comforting and companionship. Her doll would typically console her by telling her that "Things will be all right." The patient also began to speak of an enemy within, and expressed distress over different personalities that emerged unpredictably and affected her friendships in school. At this point in the treatment, Melissa announced that she could no longer tolerate returning home. She approached the school principal, requesting asylum and protection from her mother's rage regarding her refusal to return home.

Melissa did return home for another visit, with an appointment to meet with a child protective services worker to document her history. She reported her past experiences to the caseworker, who offered her 24-hour (telephone) access to crisis assistance should she feel unsafe. In the absence of recent physical abuse, Melissa felt that she would be safe. However, her meeting with the protective services caseworker precipitated a family crisis. Melissa's mother phoned the treating psychiatrist and acknowledged that some of her daughter's experiences might have been related to memories of her ex-spouse intoxicated and "on a rampage." She admitted that he had attempted to choke her as well as Melissa on several occasions. The mother requested a joint therapy session with her daughter, and during this session, reported that she had large memory gaps related to her years of marriage to Melissa's father.

### SCID-D EVALUATION

Due to Melissa's history of abusive events and symptoms of identity confusion, a comprehensive evaluation of her dissociative symptoms was performed using the *SCID-D* interview in order to rule out the presence of a dissociative disorder. The diagnostic interview was discussed with Melissa and with her consent was audiotaped. The completion of Melissa's *SCID-D* interview required five weekly sessions consisting of 50 minutes each session, as ample opportunity was allowed for Melissa to elaborate on the questions on the *SCID-D* and responses which were relevant to treatment issues were also explored. Scoring and interpretation of the *SCID-D* was performed according to the guidelines of the *Interviewer's Guide to the SCID-D* (Steinberg, 1994b).

### *SCID-D Amnesia History*

Amnesia, as evaluated on the *SCID-D*, is the inability to recall one's past or other personal information. Clinically significant examples of amnesia include failure to recall years of one's life or the inability to remember one's name, age, or address. Patients suffering from dissociative disorders are often amnesic for segments of their past that included emotional, physical or sexual abuse. As adults, these patients can become amnesic for hours, days or years of their life. In addition, they may be amnesic for their amnesia, i.e. unable to remember episodes or periods of forgetfulness.

The first *SCID-D* question on amnesia asks about memory gaps. The following is an excerpt of Melissa's replies during this section of the interview:

Interviewer: Have you ever felt as if there were large-gaps in your memory?

Subject: Yes.

Interviewer: What was that experience like?

Subject: That was strange, I would say, 'cause it's like you can remember things for a while and they just kind of stay back in your memory, back in your head, and



then something brings them out...

**Interviewer:** Have there ever been hours or days that seemed to be missing that you couldn't account for?

**Subject:** ...Sometimes.

**Interviewer:** How often does that occur?

**Subject:** Not often at all. It occurred over the summer, though.

**Interviewer:** How many times over the summer?

**Subject:** I would say lots.

In addition to being amnesic for segments of her past, Melissa also endorsed having day-to-day difficulty with her memory:

- I:** Has there ever been a time when you had difficulty remembering daily activities?
- S:** A couple of times. Like when I would talk about my schedule to a friend, I would be like, "What [class] do I have? What do I have? What do I have?" Oh, man. Like I'd be afraid that I was going to forget one of my classes and go to the wrong one.

Melissa acknowledged extensive gaps in her memory; moreover, her episodes of amnesia interfered with her social functioning and caused her significant distress. She added that her friends "stay away from me sometimes".

### *SCID-D Depersonalization History*

Depersonalization is characterized by a detachment from one's self or body, and is often described as feeling unreal. Manifestations include feeling that one's life is like a movie, feeling like a robot, feeling dead or invisible, and feeling like an observer of one's life. Melissa endorsed several manifestations of depersonalization, including frequent feelings that her body was foreign to her, which were related to a negative body-image, as well as frequent episodes of feeling unreal. She also endorsed daily episodes of feeling like a stranger to herself, and frequent episodes of feeling as if she were fading away, as described below:

- I:** Have you ever had the feeling that you were a stranger to yourself?
- S:** Yes. Very much so. I don't even know who I am sometimes.
- I:** What's that experience like?
- S:** It's like when people ask me, "Tell me something about yourself." You know, you say your name, your age, and where you're from, and that's it... I change

so much that I don't remember who I am, you know, what I was like before, or maybe I don't even know who I was at all. Maybe before, I wasn't myself.

- I:** How often does that happen?
- S:** Every day.
- I:** Have you ever felt that you were fading away?
- S:** Yeah.
- I:** What's that experience like?
- S:** It's kind of like you're melting away, like if somebody poured some water on sugar, and it would, you know, dissolve.

A common manifestation of depersonalization described by patients during *SCID-D* interviews is a splitting of the self between an observer and a participator. In this form of depersonalization, one part of the self is experienced as taking part in the activities of life and another part is experienced as watching, or observing the actions of the first part. Patients with dissociative disorders sometimes spontaneously elaborate on identity confusion and/or alteration when describing this split. In this case, Melissa described daily episodes of feeling like an observer of her participant self. Her description included spontaneous elaboration on verbal abuse as well as subtle clues to identity alteration:

- I:** Have you ever felt that you were going through the motions of living but that the real you was far away from what was happening to you?
- S:** Uh huh. I felt that way at home, before, when I get yelled at about all these things. I never felt myself.
- I:** Can you say more about that experience?
- S:** I was always quiet and I was certainly not talkative like I am at school, and I didn't do much but stay in my room and read and listen to music. At school, I'm with friends a lot and I hang out. I stick to myself sometimes. And I'm involved in school activities.
- I:** How often does that feeling of going through the motions of living with the real you is far away happen?
- S:** That happens to me a lot, even when I'm here. Some days I feel like a zombie, like I'm not even alive.

Associated features of depersonalization, such as perceptual distortions and mood changes, are often experienced in conjunction with this symptom. Melissa endorsed feeling that her arms and legs were changing in size, which occurred

in conjunction with her mother's criticism of her weight. She said that almost every day, she felt her behavior and her emotions were not under her control. She described rapid shifts between moods of violent "snapping-out" and sad, depressed moods that she felt were "not her." Additionally, she mentioned daily episodes of hearing herself talking, but feeling that she was not the person choosing the words. This associated feature of depersonalization, namely lack of control over one's own behavior, emotions or speech, may be a manifestation of the presence of alter personalities in cases of DID. The host personality may passively observe, while a dissociated identity state assumes control of the mind and/or body. Up until this point in the interview, Melissa has been providing possible indications of this, with her comment that she experienced auditory hallucinations in conjunction with her altered speech patterns. The presence of alternate identities consistent with dissociated thought and speech will be assessed later in the interview.

In sum, Melissa endorsed several different forms of depersonalization, which were recurrent and persistent. These symptoms interfere with her work and school (e.g., when she daydreams) and with her friendships (e.g., when others report being afraid of her, avoiding her, or regarding her as "strange"). These episodes of depersonalization were not associated with drugs, alcohol, or medical illness. Therefore, her depersonalization was rated as *severe*, due to the frequency, distress, and dysfunction associated with this dissociative symptom.

#### *SCID-D Derealization History*

Derealization, like depersonalization, is a form of detachment from full consciousness. During episodes of derealization, the person becomes detached from normal awareness of the environment, such as a sense of the familiar with respect to friends, family members, or one's home. Derealization is commonly associated with flashbacks, experiences in which the person may withdraw from current reality and relive a traumatic memory.

Melissa endorsed repeated experiences of derealization, including occasional episodes of feeling that other people were unreal or that they were disappearing:

**I:** Have you ever felt as if familiar surroundings or people you knew were unfamiliar or unreal?

**S:** Yes. When I feel that way, it only lasts about a minute or two, but sometimes I don't know where I am. You get this odd feeling like you're somewhere and you shouldn't be. And sometimes you think it's all a story, like the people are just there, and you don't know if they're really real people.

Melissa also endorsed other manifestations of derealization, including occasional feelings that her friends were strange or foreign, or feeling puzzled as to what was real and what was unreal in her surroundings. With regard to the latter, the patient related her episodes of derealization to her concurrent depersonalization symptoms. The intercorrela-

tion of dissociative symptoms often occurs in patients with dissociative disorders. Melissa stated that these experiences interfered with her schoolwork, because they would disrupt her concentration, causing her to go "blank." They occurred in the absence of alcohol or drug consumption, or medical illness. And due to the recurrent nature of her derealization, she received a rating of 'severe.'

#### *SCID-D Identity Confusion History*

The symptom of identity confusion, as defined in the *Interviewer's Guide to the SCID-D*, involves subjective experiences of uncertainty, puzzlement or conflict regarding one's identity. Patients with dissociative disorders often describe identity confusion as an inner struggle or battle regarding their sense of self. This subjective sense of confusion in dissociative disturbances is quite different from *developmental* identity issues of normal adolescence. As one patient in the *SCID-D* field study put it, "[My identity confusion] is this feeling of being split, like you're not part of your hand...when you go through adolescence and you have an identity crisis, you know you're a whole person — you're just trying to put your values and your sense of self in place. But *this* is a feeling of being split, of not being whole." (*SCID-D* interview, unpublished transcript). Melissa endorsed daily experiences of inner struggle that were clearly dissociative in nature rather than developmental:

**I:** Have you ever felt as if there was a struggle going on inside of you as to who you really are?

**S:** Yes. I always feel that way. I mean I don't know who I am right now because I change so much....I don't know what myself is or who myself is. Sometimes I don't even know if I even exist or why I'm here. Feelings like that, or how did I get here?

**I:** Can you describe the struggle?

**S:** It's like an argument inside. 'Well, you're this person.' 'No, that's not yourself, you're *that* person'. 'Well, I think you're not. Maybe you're this person'. I mean, it's like you don't really know who you are.

**I:** And this struggle occurs how often?

**S:** That happens every day.

The experience of identity confusion often makes it difficult for Melissa to relate to other people. She reported that her homework would often be interrupted by the repeated thought "Who am I?" Additionally, spontaneous elaborations of answers to questions in the depersonalization section of the *SCID-D* revealed that Melissa experiences identity confusion in conjunction with her depersonalization ("I don't know what myself is."). The high frequency, degree of subjective distress, and dysfunction associated with her identity confusion indicates a rating of 'severe.'

## SCID-D Identity Alteration History

Identity alteration is defined by the *SCID-D* as objective behavior that indicates the assumption of a different identity or identities. This is exemplified by the subject's self-reference with different names, acting like a different person, age regression; and a variety of indirect measures such as feedback from friends and family, or finding unfamiliar objects in one's possession.

Melissa endorsed daily episodes of feeling and acting like a child, which were associated with extreme mood changes. She also reported daily episodes of behavioral alteration that were apparent to her as well as to others who were affected by them:

**I:** Have you ever been told that you seem like a completely different person?

**S:** Yes, and that haunts me. I remember one night...I asked [my friend], was she scared of me. And she said, well, she wasn't, but she was scared *for* me because I'm not the same person. And, she says, sometimes she's afraid to say things to me because she doesn't know how I'm going to act. And then she brings up an example which was that one minute if she teases me, I would laugh, and then the next minute she would tease me and I would go off the deep end."

One of the cardinal symptoms of identity alteration that occurs in patients with multiple personality disorder is the use of different names to refer to oneself. Although other symptoms of identity alteration, such as feeling like a child, can occur across a spectrum of severity, the use of different names (other than nicknames or aliases) is typically a sign of severe identity alteration. Patients with dissociative disorders may assign names to identities that exist within them, and with whom they have internal dialogues. In patients with DID, these identities assume temporary control of the person's consciousness and behavior, during which he or she may appropriate the name for him or herself, and be amnesic for these transitions at a later time. Melissa described frequent episodes of calling herself by different names, and described in some detail the different names that she used:

**I:** Have you ever referred to yourself or been told by others that you referred to yourself by different names?

**S:** Yeah. I've named different people in me. Have you ever heard of these things called "Garbage Pail Kids?" Well, that's where I got my names. I mean, maybe they're not real Garbage Pail Kids' names, but that's where I got those names, like, Freaky Freddy, Funny Frank, Depressed Doris, and Weird Wanda...

**I:** Do you know how many names there are?

**S:** I would say six or seven.

Melissa emphasized that the entities within her existed before she gave them names. She reported using these names often, and acknowledged that other people sometimes call her by these names — an important indirect measure of identity alteration:

**I:** Have other people referred to you by different names?

**S:** Well, [my friend] June would sometimes refer to me as Freaky Freddy, cause she'd be like, "Oh, shut up, Freaky Freddy." And then she'd say, "Oh, why don't you go somewhere." Or "Shut up!" like that.

Another indirect measure of identity alteration is finding items (at home) that one does not remember purchasing or otherwise acquiring. This may be called an "environmental cue," in that it provides feedback about the emergence and behavior of an alternate personality. Attentiveness to such environmental cues is an important part of diagnosis, since patients that are amnesic for the activities of alter personalities may be aware of unexplained items in their possession, and puzzled as to how they were acquired. Melissa noted that she has sometimes found personal belongings in places where she did not remember putting them, and was perplexed as to how they got there. Melissa also endorsed experiences of a kind of possession, stating that when she had "bad" thoughts, she felt like she was possessed by Satan. This occurred "tons of times." It was clear from her responses that these episodes of identity alteration were frequent, and associated with dysphoria and dysfunction (e.g., her friend admitted to being uneasy about Melissa's unpredictability). Thus, she receives a rating of 'severe' for identity alteration.

Additional information on identity confusion and alteration was further assessed by exploring associated features of identity alteration, such as rapid mood changes, fluctuations in ability, and internal dialogues. Melissa endorsed daily episodes of rapid mood changes:

**I:** Have your moods ever changed rapidly, without any reason?

**S:** That happens, like every day...It's like every minute, I won't know how I'll act. One minute, I'll act depressed, and the next minute, (lively voice) "Oh, hi, how are you?" And the next minute, (low, gruff voice) "Oh yeah," like angry.

Melissa also reported ongoing internal dialogues; she described one episode in which someone told her that she was talking to herself. She reports talking to herself silently as well as aloud, and she experienced these conversations as both similar to voices and similar to thoughts. These dialogues occurred every day.

Thus far, Melissa had given responses indicating a rating of 'severe' for all five of the dissociative symptoms assessed in the *SCID-D*. She endorsed severe amnesia, depersonalization, derealization, identity confusion, and identity alteration.



Melissa's endorsed symptoms of identity alteration were further explored by administration of selected follow-up sections of the *SCID-D*, in order to determine the distinctiveness of the personalities she has named, and to assess whether or not these identities take control over her behavior and thoughts.

**I:** Earlier you mentioned that you have felt as if there was a struggle occurring as to who you really are...Does it ever feel as if the struggle controls the way that you act or the way that you talk?

**S:** Yes. Very much.

**I:** Tell me more about that.

**S:** Well, I feel that the struggle is just so much in control that I don't really have time to think about what actually to do or say, or sometimes maybe how the other person feels, if I say or do a certain thing. It's kind of like the struggle influences me, or somebody or something, to do or say something I don't want to say.

**I:** Can you give me an example that it influenced you to say something or do something that you didn't want to do?

**S:** All right. For instance, last week, when my friend and I were kind of arguing. At breakfast time, I said something...When I said that at breakfast time, it just slipped out, it's like I didn't even have time to think about, should I wait and let her explain after breakfast, or should I just say it. It just came out too fast. It was like a ball being rolled back and forth, and I was the ball.

Thus her symptoms of identity confusion are associated with a feeling of loss of control of her speech and a feeling that "someone or something" is influencing her behavior.

Each follow-up section allows the interviewer to examine underlying symptoms of identity alteration within the context of previously endorsed symptoms. The interviewer inquires about any signs of identity alteration that accompany these other endorsed symptoms. In this case, the interviewer asks if there are names associated with the identity confusion:

**I:** Do you have names for the different sides of the struggle?

**S:** ...The depressed one is Depressed Doris, and the weird one is Weird Wanda, and the angry one is Angry Andy. The happy one is Happy Hank and the normal one is Normal Nancy. And there's a lot of other ones that I named...

**I:** How would you describe Angry Andy?

**S:** I'd describe Angry Andy like a monster. Like big, muscular, always angry, strong, and kind of like a giant, like "Don't get in my way!"

**I:** Is there an age associated with Angry Andy?

**S:** I would say he's in his fifties...He has gray hair...Normal Nancy is just kind of like me. She's somebody who looks like me and is probably in her twenties. Happy Hank is lively and he's a handsome man...tall and thin. He's probably in his early teens, like 15 or 14. Oh, Depressed Doris, oh gosh, she's like an old lady, shriveled up, like frail, and she's thin, small and is always depressed. She's probably in her nineties.

Clinicians should note that it is not unusual for DID patients in any age bracket to endorse the presence of alter personalities who are "older" than they are. In some instances, alters who represent ages that the patient has not yet attained may represent aspects of the abusive parents or other hurtful authority figures. This is especially likely to be the case if they are 'persecutor' alters, i.e., alters who sabotage the patient's life and typically try to undermine therapy (Putnam, 1989). In other instances, older alters may represent the patient's internalized ideal of a good parent or a wise teacher. The negative characteristics of Melissa's older alters — anger and depression — suggest that they may be introjects of dysfunctional family members. Like many patients with multiple personality disorder, Melissa's identity confusion often results from her interactions with the numerous named entities within her. She went on to report having dialogues with Depressed Doris, in which they would share their feelings and memories. She added that Doris's depression was contagious. Melissa mentioned that she had constant, ongoing dialogues with "Freddy," but that she rarely had conversations with Andy — usually only when she was very angry.

In addition to the administration of follow-up sections, observation of intra-interview cues of dissociation are an important part of the diagnostic process. The interviewer noted the presence of intra-interview dialogues occurring during this follow-up section on identity confusion. Melissa mentioned that "Freddy" had been co-conscious with her during the interview:

Freddy's small, but strong. He's about my age, 18. He likes to be with me a lot during the day. He's like my bodyguard...He's the one I talk to when we're in trouble. As a matter of fact, he's in here right now.

Freddy's function was described as that of the "internal self-helper," or ISH, which is often personified in patients with DID (Allison, 1974; Putnam, 1989). Melissa added that she has known Freddy for several months, and that he first appeared to soothe her when she was feeling depressed and upset about her abusive home environment.

- I:** How long have you known Freddy?
- S:** I've known Freddy for about, let's see, for half a year.
- I:** When did he come into your life?
- S:** He came in, I would say, some time in early 1990. Oh gee. I can't even think.
- I:** Do you remember what was happening when he came in?
- S:** I guess I was really depressed and I was down about things that went on at home, you know, I was tired of being picked on all the time. And then, it's really weird because all of a sudden I felt this sense of peace come over me. And then Freddy comes. At first he scared me, but then it was like I had this safe feeling.

This quote supports previous observations that alter personalities develop to help victims of abuse cope with traumatic experiences. Freddy emerged several times during the interview, such as during the follow-up on different names, when Freddy recounted abusive memories from Melissa's childhood. Freddy is a unique personality because, although Melissa is blind, Freddy is described as being sighted and able to help Melissa play goal ball, a game similar to soccer, but with auditory cues for players who are blind:

- I:** Is he [Freddy] blind, by the way? Does he read Braille?
- S:** No, he reads print...Sometimes I think Freddy tells me where the goal ball is. I think that's why I've been able to block all these balls the way I've been blocking them.

During the follow-up section on different names, Freddy talked with the interviewer for several minutes. During this time, Melissa was also co-conscious and the two had a verbal conversation out loud. At one point Angry Andy emerged and the subject verbalized a physical struggle between Andy and Freddy, alternating between different voices:

- S:** Whoa. They're fighting.
- I:** Who's fighting?
- S:** Freddy and Andy. (pause) [Andy's voice:] "Get out of here." [Freddy's voice:] "No; you get out of here, you big idiot." [Freddy's voice:] "Well, you get out of here. Stop scaring her." [Andy's voice:] "No!". [Melissa's voice:] "Oh, gosh. Now Freddy's got a bloody lip... (laughs) now Angry Andy's crying (teasing laugh) Go Freddy go! Go Freddy go! Yeah! Oooh. He's jumping right on him. All right. I wish I had a goal ball here. I would just take him, and

beat him with it."

This episode reflects a common manifestation of identity confusion in patients with DID, in which the conflicting sides of the struggle are personified and may actually be perceived as individuals who are engaged in physical combat. The internal struggle may be a behavioral memory of violent experiences of an abusive past.

Later in the interview, Melissa mentioned a personality named "Childish Chris," who was five years old and from Bulgaria. The presence of younger alters is common in patients with DID, who experience age regression when taking on the persona of the younger alter:

- I:** Who's the youngest part of you?
- S:** Oh, that's Childish Chris. She's only about five.
- I:** Can you say any more about her?
- S:** She's interesting. Oh, here she comes, too. Gee, speak of the devil. She's really interesting. She's like small and thin, and she's got this real long hair. She's— Oh let me see. What kind of person, where's she from? She's Bulgarian... [changes to high voice and foreign accent] I came over from Bulgaria when I was three and [Melissa's voice:] She has to think about how she's saying things, 'cause she's only been over here for two years. [Chris' voice:] I like to be childish. I like to be totally off the wall and sometimes I get really crazy.

Amnesia for events or experiences associated with episodes when an altered identity emerges is common in individuals with multiple personality disorder. The existence of inter-personality amnesia is such a distinctive characteristic of DID that it has its own diagnostic criteria in the *DSM-IV* DID diagnosis. Melissa said that the parts within her had different memories, and that they remembered events corresponding to the mood associated with the personality. Such linking of separate memories with separate affect supports state-dependent theories of DID development (Braun, 1988; Ludwig, 1966; Putnam, 1989; Swanson & Kinsbourne, 1979; van der Kolk & van der Hart, 1989).

- I:** Does each side of the struggle have different memories?
- S:** Sometimes they do.
- I:** How are they different?
- S:** Well, some of the memories, like the depressed side of it, has when my mother was talking to me about my weight...when I'm at home and my mom yells at me about my weight and constantly puts me on the scale – that keeps coming back...The sad side of it, I guess, was when my grandfather died, when



my great-grandmother died, when my mom and dad divorced, the fact that I don't see my dad very much. The happy side is just remembering the good times when I was at my other school...and my friends and I would hang out and we would do different things like be silly and go places together.

**I:** ...Do they know different things about your background?

**S:** To tell you the truth, I think they do, but I think there are some things they know that I don't know.

Differentiation between moderate and severe identity alteration through the assessment of the degree of similarity of the patient's identity states can be accomplished by asking whether the personalities seem to have different memories, skills, or abilities. In addition to endorsing separate memories for the personalities, Melissa felt that the different parts of her controlled the way she acts. She associated her mood changes with the actions of the personalities, and said that the personalities caused her to feel, say or do different things:

**I:** Do they have different skills, the different parts of you?

**S:** I would say they do. Like the depressed one has the skill of making other people depressed. And the happy part just has the skill of respecting people. And the angry part just has the skill of letting off steam.

Once the five symptoms have been assessed and the follow-up sections have been administered, it is possible to rule out a diagnosis of dissociative disorder based on *DSM-IV*. The reader is referred to Figure 1, "SCID-D Differential Diagnosis Decision Tree," for a visual summary of the process of differential diagnosis.

#### *Summary of Dissociative Symptoms and Diagnosis of Dissociative Disorder*

Melissa reported experiencing all five of the dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration. Based on the frequency of occurrence, and the degree of dysfunction and distress caused by her symptoms, she was given the highest rating — 'severe' — for all five symptoms, according to the *Severity Rating Definitions of the Interviewer's Guide to the SCID-D* (Steinberg, 1994b). Based on Melissa's responses, she meets *DSM-IV* criterion A for DID; specifically, she endorses several identities with relatively distinct and complex personality characteristics (American Psychiatric Association, 1994). She mentioned different names and skills associated with the personalities. In responses to questions regarding identity alteration, Melissa reports being called by the names she has given to her internal personalities, feelings of possession, and frequent experiences of severe mood changes asso-

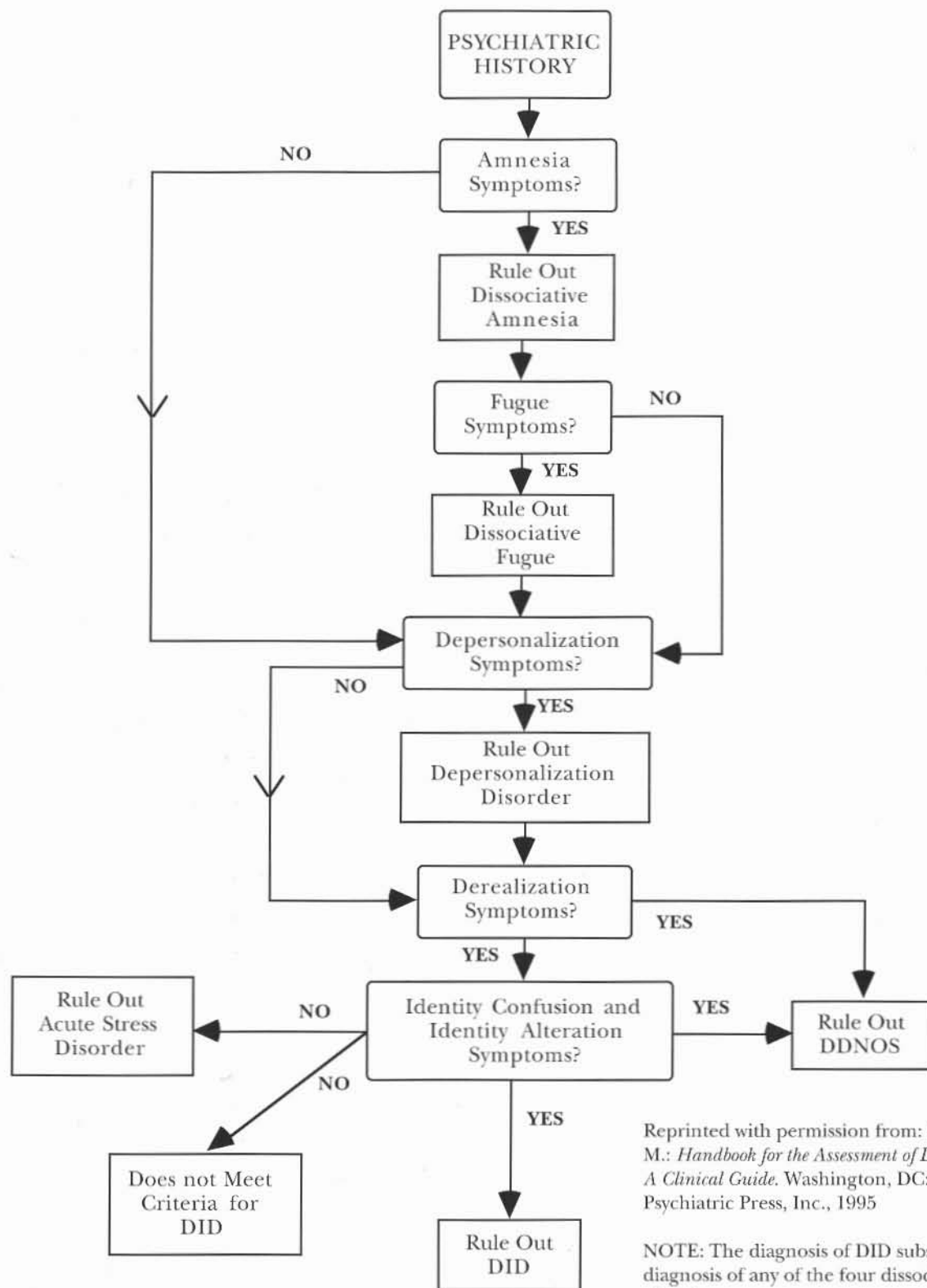
ciated with identity switching. Finally, in the *SCID-D*'s follow-up sections, the interviewer observed several episodes of intra-interview identity alteration. For instance, Melissa assumed the identities of Angry Andy, Freaky Freddy, and Childish Chris. Therefore, it is concluded that these identities "recurrently take control of the person's behavior" (*DSM-IV* DID criterion B) (American Psychiatric Association, 1994, p. 487). Melissa also satisfies *DSM-IV* DID Criterion C, "Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness" (American Psychiatric Association, 1994, p. 487) due to her positive endorsements in the amnesia section and her spontaneous elaborations in the depersonalization section ("I don't remember who I am"). Finally, *DSM-IV* Criterion D states that the disturbance is "not due to the direct effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures)" (American Psychiatric Association, 1994, p. 487). In this case, the subject does not use alcohol or drugs and has not reported a coexisting medical condition. Because the subject meets all four *DSM-IV* criteria for multiple personality disorder, she was given a diagnosis of Dissociative Identity Disorder.

#### **COURSE OF TREATMENT FOLLOWING THE SCID-D EVALUATION**

Following elucidation of her altered personality states in the *SCID-D* interview, the dissociative symptoms were explored further with Melissa. She reported that she found the process of the interview extremely helpful in helping her to bring forth inner experiences previously hidden and never articulated. Melissa came to subsequent sessions reporting that she had not seen a specific alter, Freddy, for some time. She wondered if he or she had left permanently, and expressed both sadness regarding the loss of a companion and satisfaction regarding the increasing coherence of her life. Her somatic, tactile, olfactory, and auditory hallucinations ceased temporarily, reappeared at the end of the school year and stopped again after an alternative plan to returning home was established. Before her departure, she announced "No one is around except Angry Andy and Freddy, and I say, hey, Angry Andy, I've got a nice present for you... and it's called happiness. Man, this is *fun* telling him off."

For this patient, the *SCID-D* was useful not only as a diagnostic tool, but also enhancing the therapeutic process in elucidating her dissociative symptomatology, revealing previously unexplored material. Follow-up sessions following the administration of the instrument are often helpful in patient education. In this case, explaining to Melissa the nature and prognosis of her symptoms was the first step toward her acceptance of her alternate personalities. Thus, the *SCID-D* interview was clearly an instrument of change for this young woman, fostering a greater degree of cooperation among her alters which is a precondition for eventual integration.

FIGURE 1  
SCID-D Decision Tree for the Dissociative Disorders



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NOTE: The diagnosis of DID subsumes the diagnosis of any of the four dissociative disorders.

## SUMMARY

This case study has demonstrated that the systematic assessment of dissociative symptoms using the *SCID-D* allowed for the diagnosis of DID in an adolescent who is blind. In fact, her descriptions of the five specific dissociative symptoms were virtually identical to those given by adult patients without visual handicaps who suffer from DID (see Steinberg et al., 1993). Remarkably vivid and even visual descriptions of her alternate personalities, including their hair color, were given by this patient. The efficacy of the *SCID-D* in the evaluation of dissociative symptoms and detection of the dissociative disorders in individuals who are blind is particularly important, given that the incidence of dissociative disorders and their antecedent traumatic history among individuals with disabilities is unknown.

Because the *SCID-D* is a clinician-administered interview, it can be useful in assessing patients who are visually impaired for histories of dissociative symptoms and disorders. Screening for these symptoms should be included in the diagnostic assessment of all patients with reported or suspected histories of trauma. As individuals with disabilities are likely to have an elevated risk of trauma and dissociation histories, routine assessment of these factors is essential. The systematic assessment of dissociative symptoms using a structured interview such as the *SCID-D* can accurately detect the presence and severity of dissociative disorders in individuals with disabilities, and facilitate referral to appropriate treatment. The clinical psychiatric screening of sub-populations such as patients who are deaf requires the development of diagnostic tools that are adapted for and validated in a visually accessible language such as American Sign Language. Further research is needed to systematically assess histories of trauma and dissociative symptoms and disorders among individuals with disabilities. ■

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