Multiple Personality Disorder in Children

Clinical Features of Multiple Personality Disorder (MPD)

The DSM-III-R (Diagnostic Statistical Manual, Third Edition, Revised) uses the same criteria for MPD in people of all ages: “a) the existence within the person of two or more distinct personalities or personality states, and b) at least two of the personalities or personality states recurrently take full control of the person’s behavior” (American Psychiatric Association, 1987, p 272). The next edition, DSM IV, is expected to include a third criteria, “amnesia for significant information that can’t be explained on the basis of ordinary forgetting.”

According to Putnam (1989), the clinical features of adult MPD are remarkably constant. He suggests that reading a sampling of cases leads to the feeling that “if you have read one case, you have read them all.” He lists the prominent features of MPD as follows:

- Sudden, dramatic transformations to a side of the self at great odds with prior behavior (called an alter);
- Often the new aspect of the personality is childlike and differs in speech, mannerisms, affect, preferences (such as food) and physiological responses (such as pain sensitivity and somatic symptoms);
- The transition is rapid and often related to environmental stimuli;
- An amnesiac barrier separates personalities (it may be that one personality has information about the other but not vice versa);
- The host personality (the personality in control most of the time) is often depressed and dejected;
- MPD clients commonly describe headaches, auditory hallucinations and gastrointestinal disturbances.

In contrast, childhood MPD can present in a variety of ways (Fagan and McMahon, 1984; Kluft, 1985; The Network, 1989; Putnam, 1993; Vincent and Pickering, 1988) and the child, therefore, may fulfill diagnostic criteria for several different disorders. Referral problems can include depression, oppositional behavior, conduct disorders, learning disabilities and borderline personality characteristics. However, children may present with psychotic-like symptoms, especially auditory hallucinations, often with suicidal or homicidal content.

Children with MPD may have an active, imaginary friend, the child may be called a liar (because he/she disavows witnessed behaviors) and there are generally muted signs of adult MPD (Kluft, 1985). Truancy for as much as five years has been noted (Fagan and McMahon, 1984). There may be dramatic fluctuation in school performance and failure in school may be a major complication.

Estelle is one of the earliest documented cases of childhood multiple personality disorder. Estelle L. was born in 1825 in Paris, France, to a comfortable upper-middle-class French family. When Estelle was five, Paris was ravaged by a measles epidemic. She became very ill, suffering from high fevers and neurological symptoms. Two years later, there was a cholera epidemic which took the life of Estelle’s father and almost killed her mother and sister. After the epidemic, her family noticed changes in Estelle. She became extremely sensitive and hyper-imaginative.

Two years later, while playing with a friend, Estelle fell on her bottom. This marked the onset of increased symptoms, including frequent headaches, a nervous cough, oppression in the chest, pain in the stomach and rib cage and neuralgia. She slowly reduced her physical activity and eventually stopped walking altogether. She was always cold and, according to others, developed bizarre eating patterns.

Estelle was taken to Antoine Despine, a physician who, while practicing traditional methods, was also known for using some controversial techniques, such as artificial somnambulism (hypnosis). The psychological features of Estelle’s illness were vague. So Despine treated her physical symptoms by traditional means. However, during a conversation with Despine, Estelle’s mother confided she had overheard what sounded like a two-way conversation in Estelle’s room while Estelle was alone. It was then that Despine proposed the idea of somnambulism. The course of treatment resulted in the discovery of “Angelina,” an inner self-helper who dictated the treatment course. Further treatment resulted in the discovery of other alters: “Zeal,” “Pansy,” “Eloina,” “The Skeleton,” “Henrietta,” “an old dead woman,” “men who scared her by their grimes,” “people in domestic altercations,” “Mademoiselle,” and another “Estelle.” Prolonged treatment resulted in an adolescent who, though somewhat weaker than her peers, was anxious to return to her friends and to live a normal life. In 1837, treatment with Despine ended. While there were plans for Estelle to return in a year, there is no documentation that the return occurred.

(Excerpted from Fine, 1988.)

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(Gould, Graham-Constain, Peterson and Waterbury, 1993; Kluft, 1985). Any of these symptoms can, of course, occur in normal children or in those with other diagnoses.

Gould and her colleagues have proposed a separate diagnostic category, "Dissociative Disorder of Childhood." Children diagnosed with this label would not meet the criteria for adult MPD. Instead, the child exhibits, over at least a six-month period of time, recurrent amnesia and frequent trance-like states. In addition, the child shows at least two perplexing, major fluctuations in mood and behavior, and at least three of nine other symptoms (including referring to self in third person, having vivid imaginary companions, frequently disavowing observed behavior, frequent inappropriate sexual behavior). This formulation is helpful in organizing differences between childhood manifestation of MPD and the adult disorder. However, these ideas have yet to gain official sanction. Until then, the concept of "Dissociative Disorder of Childhood" cannot be a diagnosis, although it may provide a framework for research.

History of MPD

Putnam (1989) offers a chronology of interest and research into MPD. According to Putnam, Pierre Janet (1859-1947), while acknowledging the influence of others, was the first clinician and researcher to inquire about the nature of dissociation. An American, William James, was captured by Janet’s ideas and discussed his own work on dissociation at the 1896 Lowell Lectures. These early pioneers and their students and colleagues took an experimental approach towards dissociation. From 1880 to 1920 there was a great flourishing of interest in MPD and a relatively large number of cases were reported, especially in France and the United States. Many very detailed cases were published.

However, in the 1920s a decline in interest in MPD began and lasted until the 1970s. One of the factors contributing to the nadir of interest was the assertion by psychoanalysts that repression was responsible for banishing unacceptable material from conscious awareness and voluntary recall. Cases of MPD reported by these using hypnosis were regarded as artifacts induced by the hypnotic process. Marcia Waterbury, M.D., is a clinical assistant professor of psychiatry at the University of Maryland School of Medicine. She comments, "Around the turn of the century, multiple personality was actually a very acceptable diagnosis. With the influence of the Freudian school of thought, the concept of dissociation was replaced with the concept of repression."

A second factor contributing to a decline of interest in MPD was the increase in the use of the diagnosis of schizophrenia. Interest in this condition led to overdiagnosis and inclusion of clients who were probably MPD.

A few cases of MPD continued to be reported in the literature. Most notable of these was "The Three Faces of Eve" (Thigpen and Cheekley, 1957). However, for the most part, MPD was regarded as a rare phenomenon.

The rebirth of interest in the 1970s reflected several converging trends. One was the interest in post-traumatic stress disorder which caused researchers to again investigate dissociation. According to Putnam, researchers found a rate of dissociative disorders in military psychiatric populations of 1.3 percent. Other studies show that 5 to 14 percent of psychiatric combat casualties had dissociative symptoms.

A second factor in the renewed interest in MPD was the increased awareness of child abuse and its devastating consequences. Third was a renewed interest in hypnosis by both researchers and clinicians. Studies on hypnosis demonstrated that hypnotic susceptibility was related to potential for dissociation.

A fourth factor was the research that led to tightening and clarifying the diagnosis of schizophrenia. Lacking evidence of formal thought disorder required by the more rigorous definition of schizophrenia, MPD patients no longer fit the criteria for psychosis. Putnam credits DSM-III as helping revive interest in MPD by establishing a separate diagnostic category for dissociative disorders.

The 1970s work of Arnold Ludwig, Cornelia Wilbur and their associates at the University of Kentucky resulted in a series of MPD case reports, one of which was Sybil. Since the 1970s, interest in MPD has mushroomed as have case reports.

Incidence

Incidence of MPD in adults was considered rare until recently. Up through the 1960s, cases of MPD reported in the literature over the prior 100 years totalled only around 200 (Weiss, Sutton and Utecht, 1985). Kluft’s review (1985) stated that the literature of the 19th and 20th century was dominated by single case studies. Kluft notes that prior to 1980, only one large series of MPD cases were reported in the literature. Thus, since 1980, more cases have been identified than in all the years preceding 1980.

There is a consensus in the literature that MPD has its roots in childhood and is established by the age of 8 at the latest (Fagan and McMahon, 1984). However, until recently it was rarely diagnosed before adulthood. Peterson (1990) reports that only 11 percent of the total number of multiple personality disorder diagnoses were made before the client was 20 years old, with only 3 percent made prior to age 12. It is just in recent years that there are discussions of contemporary cases of children appearing in the literature (Bowman, Blix and Coons, 1985; Fagan and McMahon, 1984; Hornstein and Tyson, 1991; Kluft, 1985; Malenbaum and Russell, 1987; Weiss, Sutton and Utecht, 1985; Coons, 1986). According to Kluft (1985), childhood multiple personality was absent from the literature until the 1970s. Excepting Despina’s account of Estelle, Kluft believes that his 1979 presentation at the American Psychiatric Association annual meeting was the first account of MPD in a child. Kluft reported on an 8-year-old boy.

Ross (1989) reviews the incidence data on childhood MPD. He states that in their 1988 review of the literature, Vincent and Pickering (1988) identified only 12 reported cases. At the time of Ross’ writing, he was aware of only eight “modern” cases of full MPD in childhood. Five of these had been reported by Kluft and one each by three other groups.

Incidence of MPD in children is difficult to assess because, according to Kluft, dissociative disorders are largely undiagnosed in children. After studying, in retrospect, the records of 20 successfully treated adults, Kluft concluded that the signs of florid dissociation if not full blown MPD were evident but undiagnosed in their childhood. Despite diagnostic problems, Reagor, Kasten, and Morelli (1992) recommend, based on their research, that all children with known abuse histories be evaluated for MPD/Dissociative Disorder.

Causes

Why do children dissociate? What causes the formation of multiple personalities?

There is general agreement in the literature that early, ongoing incidence of abuse or trauma trigger the onset of multiple personalities (Braun and Sachs, 1985; Fine, 1988; Kluft, 1985; Lewis, no date; Vincent and Pickering, 1988; Young, 1988). “Development of alternate personalities at... an early age is consistent with
the developmental characteristics of young children, particularly their ability to use fantasy to interpret and understand their developing reality, and in traumatic situations, to escape from being psychically overwhelmed.” (Vincent and Pickering, 1988, p. 525).

The literature points to a direct link between severe child abuse and MPD. In his review, Braun (1990) reported that five major studies made clear the etiologic link, with investigators reporting that, in patients with MPD, between 95.2 percent to 98 percent had been abused in childhood. These studies also indicate that over 80 percent were sexually abused. The National Institute of Mental Health (Putnam, 1989) conducted a survey of 100 MPD cases and found that 97 percent of all MPD patients reported experiencing significant trauma in childhood, with incest being the most commonly reported trauma (68 percent).

Putnam (1989) gives a historical perspective of reported cases of MPD that are linked to sexual abuse. It was in 1926 that Goddard first reported incest in connection with his case. However, he implied that he did not believe the patient. It was not until 1930 that Morselli reported the relationship between a case of MPD and incestuous sexual abuse that was corroborated by independent sources. No other reports appear until into the 1970s, when cases such as Sybil appeared.

While these reports do not prove that childhood abuse causes MPD, they certainly form a strong link between the two. Braun (1990) suggests, however, that it may not be the sexual abuse or the constellation of several forms of abuse that cause MPD in incest. Rather, the more important factor may be that the abuse “is administered unpredictably by an adult who is a nurturing relative at other times. The severity of dissociation and MPD is more directly related to abuse that is administered by parents or other family members who are able to give love and protection... and the child must deal psychodynamically with unpredictable infliction of abuse versus expression of love. When the state of affairs is overwhelming, psychic defenses must be erected.” (p. 228) For those predisposed to it, this defense may be dissociation.

Other than child abuse or child sexual abuse, several traumatic circumstances have been determined as causative factors for MPD. These include witnessing the violent or traumatic death of caretakers or loved ones, experiencing other traumatic conditions due to war and dealing with chronic and debilitating pain.

Dissociation resulting in the formation of other personalities is a protective and inhibitory device used by the person to maintain conflict-laden material in dissociated states, away from conscious awareness. Catherine Gould, Ph.D., is a clinical psychologist who has conducted more than 50 training workshops about MPD and ritual abuse. Gould explains, “A child who has fully dissociated a traumatic memory may not have multiple personalities, but has some internal dissociative process that needs to be addressed.”

Must one be vulnerable to the disorder, or can multiple personality disorder occur in anyone? According to Braun and Sachs (1985), the second essential feature for the formation of alter personalities (other than the presence of ongoing and severe trauma) is “a natural, inborn capacity to dissociate” (p. 42). This capacity appears to have biological determinants (Braun and Sachs, 1985; Lewis, no date; Young, 1988).

Evidence for a biological basis comes in part from research on the distribution of hypnotic susceptibility in the normal population. Hypnotic susceptibility is correlated with the potential for dissociation. The fact that multiple personality disorder occurs across generations has been cited as supporting evidence. Many cross-generational cases appear to occur, however, because the violent, assaultive alter of a parent has abused the MPD child (Kluft, 1985; Malmenbaum and Russell, 1987). Therefore, the question remains uncertain as to whether this is due to genetic factors or parental abuse.

What is it?

MPD — According to DSM III-R (1987) the official diagnostic manual of the American Psychiatric Association, there are two criteria for MPD: a) the existence within the individual of two or more distinct personalities or personality states, each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and one’s self; b) each of the personality states at some time and recurrently takes control of the individual’s behavior. A third criterion to be added in the DSM IV is amnesia for significant information that can not be explained by ordinary forgetting.

Alter — An alter is not a separate person, but part of a person, “an entity with a firm persistent and well-founded sense of self and a characteristic and constant pattern of behavior and feelings in response to a given stimuli. It must have a range of functions, a range of emotional reactions and a significant life history” (Kluft, 1984, p.23).

Personality Fragments — Pieces that fail to meet the definitions of alters (typically store one emotion or perform one activity).

Host — “the one who has the executive control of the body the greatest percentage of the time” (Kluft, 1984, p.23).

Dissociation — A normal process used defensively by an individual to handle trauma whereby the person “compartmentalizes” or separates the traumatic material from the rest of consciousness and does not integrate the experience. Dissociation exists in a continuum from daydreaming to MPD.

Repression — A process where unacceptable material is relegated to the unconscious and thus is not accessible to the individual. Repression is a different and separate process from dissociation.

DSM-III — The third edition of the Diagnostic Statistical Manual of the American Psychiatric Association. This volume defines the official criteria for all emotional and mental disorders. DSM IV is scheduled to be published soon.

Abreaction — When a person remembers an event and re-experiences the emotions of that event, usually in a sudden, violent outburst. The released emotion and memory can then be interpreted and integrated.
child abuse) instead creates a situation in which it is adaptive for the child to heighten the separation between behavioral states, in order to compartmentalize overwhelming affects and memories generated by the trauma. In particular, children may use their enhanced dissociative capacity to escape from the trauma by specifically entering into dissociative states. Dissociative states of consciousness have long been recognized as adaptive responses to acute trauma, because they provide (1) escape from the constraints of reality; (2) containment of traumatic memories and affects outside of normal conscious awareness; (3) alteration of detachment of sense of self (so that the trauma happens to someone else or to a depersonalized self); and (4) analgesia.

In most MPD cases, the abuse is inflicted by a parent or other caretaking figure. One of the most important tasks of a caretaker, particularly in early childhood, is helping the infant or toddler to enter and sustain a behavioral state that is appropriate to the circumstances... It is easy to speculate that bad parenting accompanying abuse fails to aid the child in learning to modulate behavior states” (p. 53).

While MPD can be viewed as a “problem” or a “cluster of symptoms,” Waterbury offers another viewpoint. She notes, “The children are trapped, but can escape in their minds. It’s a wonderful gift!”

Diagnostic Implications

Putnam notes two changes in clinical features when comparing early cases of adult MPD to those diagnosed recently. The first difference is in the number of alters identified. Many early cases identified only dual personalities and rarely identified more than four alters. Currently, the number of alters identified averages 15. Cases with over 50 alters are not unusual. Part of the difficulty is in lack of clarity about how to “count” alters. Some clinicians may be including personality fragments that hold only a single emotion or activity as separate alters. Personality fragments are not alters. Putnam notes that clinicians should be able to specify criteria for alters.

The second change over time is the gradual consensus that MPD is caused solely by traumatic childhood experiences. Most adults and children being treated are felt to be victims of child abuse or child sexual abuse. The remainder have witnessed the violent and traumatic deaths of loved ones and/or are victims of experiences of war. In rare cases, debilitating injury and sustained pain is the traumatic stimulus.

Children with MPD may present a different picture than adults, making the diagnosis difficult. Clinicians are accustomed to thinking of symptoms and behaviors indicative of MPD in terms of adults. Further, due to a lack of published information, clinicians have little or no index of suspicion about childhood MPD and consider the disorder to be rare (Kluft, 1985; Reagor, Kasten and Morelli, 1992). Peterson (1990) summarizes the differences found in the literature. Child and adolescent personalities may not be well enough developed to display complex personalities as their alters.

Thus, the personalities appear to be less clearly defined (Kluft, 1985; Lewis, no date; Vincent and Pickering, 1988). There may be little difference between the young alters and age-appropriate behaviors of a child. Also, some of the common manifestations of MPD in adulthood do not appear to be present in children. Persecutor personalities, inner self-helper personalities, special-purpose fragments and systems of personalities are not commonly reported in childhood MPD, and, therefore, may not exist in childhood disorders. Somatoform complaints and severe headaches are uncommon in children with MPD or exhibit as occasional and vague symptoms. The single best predictor of a childhood dissociative disorder is thought to be “frequent trance-like behavior” (Putnam, 1993).

Children with MPD can easily be misdiagnosed, according to Vicki Graham-Costain, Ph.D., a clinical psychologist specializing in the treatment of child and adult survivors of sexual abuse. She explains, “It is not unusual for children with MPD to be misdiagnosed as Attention-Deficit Disorder, Anxiety Disorder or Conduct Disorder.” An MPD child who has experienced massive trauma has parts which are very anxious. If an aggressive personality takes control, the child may appear conduct disordered. A child may also be misdiagnosed as mood disordered due to sudden fluctuations in emotions.

Few cases of childhood MPD, then, are meeting the criteria for MPD in the DSM-III-R. Peterson (1990) suggests that the adult criteria is inappropriate for children for a variety of reasons, and like Gould and her colleagues (1993) advocates for the establishment of separate criteria and placement in the child and adolescent section of the manual. A separate diagnostic category offers many advantages to both clinicians and families. The diagnosis of dissociative disorder or MPD in children would be less intimidating to the family and community if located in the child section. Having a separate category would encourage clinicians to consider the possibility of a dissociative disorder and a dissociative identity disorder could be used as an interim diagnosis until MPD is ruled out.

Standardized tests and personality measures are often helpful in diagnosing mental disorders and emotional problems. Thus far, however, this does not appear to be the case for diagnosing MPD. For adults, the MMPI has been found to be of questionable value in diagnosing MPD, even though some researchers have reported consistent elevations on certain scales. The difficulty in interpretation is that there are elevations on other scales as well, with no consistency from patient to patient. Bliss (1984) states that “it seems likely that this typical MMPI profile may be suggestive but not diagnostic” (p. 199).


Several clinicians have published list of predictors for childhood MPD. Putnam (1989) offers 12, Kluft (1984) offers 16, and Fagan and McMahon (1984) published a list of 20 symptom behaviors that can be observed and six additional subjective experiences.

Several scales specific to diagnosing dissociative disorders are available. All are relatively new, but some show good reliability in studies performed to date. Some scales were available for review and are described in the resources section for this issue.

Bernstein and Putnam (1986) developed the 28 item Dissociative Experience Scale (DES) as a means of reliably measuring dissociation in adults. However, the scale is not designed as a diagnostic tool. Rather, it’s current use is limited to research and screening. Initial studies show that persons with MPD have the highest scores on the DES. However,
those experiencing Post-traumatic Stress Disorder also obtain high scores (Putnam, 1989).

The Structured Clinical Interview for DSM-III-R Dissociative Disorders (SCID-D) by Steinberg (1987) has recently been republished (1993) in updated format to reflect changes in DSM-IV. This format is a semi-structured interview used by an experienced clinician to access the nature and severity of dissociative symptoms. The drawback of this technique is the need for considerable training and expertise prior to use.

Ross and associates (1989) have published the Dissociative Disorders Interview Schedule (DDIS). Initial reliability studies have been very positive, and the DDIS can be administered in less than an hour.

Presently, there appears to be little research about the use of standardized tests for the diagnosis of MPD in children. The recent publication of the Child/Adolescent Dissociation Checklist (Reagor, 1988) is a potentially useful tool for diagnosing children although Reagor cautions that the instrument is a screening tool, not a formal standardized diagnostic instrument. Putnam (1989), who designed the Child Dissociation Checklist, summarizes current practice when he states that he is not aware of any behavior or symptom rating scale that can be used to adequately access children for the presence of dissociative symptoms on an ongoing basis.

Obviously, there is a pressing need for adequate criteria. Unless adequate criteria are delineated and unless clinicians can agree upon and demonstrate reliability in their work, data will be limited to case reports or samples that vary so much that the results of studies will not apply to other clinician's cases.

**Intervention**

First and foremost, a child with MPD must no longer be subjected to the stresses that caused the disorder. Otherwise, recovery from the disorder is unlikely (Riley and Meade, 1988). Since it is assumed that trauma has caused the problem, and since the overwhelming majority of cases are presumed due to child abuse or child sexual abuse, a clinician must evaluate whether or not a child abuse report is required. Even though an MPD diagnosis assumes a history of trauma, the diagnosis alone may not be sufficient to trigger reporting. "Decisions about child abuse reporting in cases of MPD children need to be made on a case-by-case basis. Local departments of social services are available for consultation," states Suzanne Fountain, CPS Program Consultant with Virginia's Department of Social Services.

Lowell Routley, Ph.D.

VCPP interviewed 12 practicing clinicians. When asked about referral to child protective services based on a diagnosis of MPD, most clinicians responded that they did not or would not automatically make a referral. Lowell Routley, Ph.D., from Dubuque, Iowa, chairs the Iowa Professional Study Group for Dissociation and MPD. His response to the question of child abuse reporting was typical. "Reporting possible child abuse is something a clinician struggles with. If we were to make referrals solely on the basis of dissociative symptoms, a family could easily disguise the abuse and a failed investigation would merely reinforce the power of the family."

Routley comments about an effective investigation into possible abuse for dissociative children. "First one must rule out any organic basis for the child's symptoms. High-fevers, physical trauma such as burns or car accidents, or affective disorders can produce dissociative symptoms without an abuse etiology," he states. Routley also rules out a family history of dissociation. If there is a hereditary propensity to dissociate, the child may be using the skill as an automatic native defense.

There are also child abuse issues for those treating adult MPD clients. Paul Dell, Ph.D., a therapist at the Trauma Recovery Center in Norfolk, Va., comments, "With adult MPD clients, there may be an abusive alter who is dangerous to children. The adult therapist has an obligation to screen children of MPD clients to determine whether or not abuse by an alter is occurring. If there is an abusive alter, the child or children should be removed to a safe environment and a report to CPS must be made."

Routley agrees about the need to screen children of multiples. "The parent may have entered treatment wanting the therapist to detect and stop the abuse," he states. Dell notes that a report to CPS can be devastating for the adult with MPD. "The revelation of an abusive alter is traumatic for the MPD client who can become suicidal." Thus, therapists dealing with the necessity of a CPS report should take care to offer additional support to the adult MPD client and to assess suicidal potential and/or the need for hospitalization.

Dell's observations are interesting and appear to be absent from discussion in the literature. No written source was found that addressed making a suspected child abuse report when diagnosing MPD in children, modification of procedures when investigating a case where a child has been diagnosed as MPD, or responsibility of the therapist to assess the safety of the adult MPD client's children. These practical issues appear to merit thought and discussion, as clinicians need guidelines to formulate effective intervention procedures.

**Treatment**

Hornstein and Tyson (1991) divide the therapeutic intervention into six tasks:

Task 1: The establishment of a safe, nurturing environment for the child.

Hornstein and Tyson (1991) make a strong statement regarding the importance of this task. "The establishment of a safe and nurturing environment is of primary importance in the treatment of these children. Until this is accomplished, no attempt should be made to erode the child's dissociative defenses, because doing so leaves the child in a state of increased vulnerability to further trauma. Failure to attend to this basic issue is at the root of many 'treatment failures,' including the child's apparent inability to gain mastery over destructive behaviors." (p. 640).

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Trauma Recovery Center
Program of Psychotherapy
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The Trauma Recovery Center provides a program of training on trauma and dissociation. Paul Dell, Ph.D., Elizabeth Gay, M.S.W., and Betty Kidrock, M.S.W., offer both initial and advanced training. Trainings are designed to address traumas of childhood abuse, societal violence and precipitous disasters (fires, floods, accidents). Teaching methods include lecture, discussion, video tapes, case consultation and live supervision.

The basic training program, an eight-session monthly workshop of five-and-a-half hours, runs from October to June and costs $640 ($200 for full-time students). The advanced training program begins in October 1994. In addition, an advanced consultation group meets monthly for six sessions for an hour-and-a-half each time. This fee is $180 or $30 per group. Training for group work with trauma survivors, a one-day, six-and-a-half hour workshop costs $85.
Hornstein and Tyson suggest that the particular "safe and nurturing environment" will depend on the individual needs of a child. "It is critical to evaluate a child's needs in this regard" (p. 641). Some children will need to be in an inpatient environment, others will not. Some children who have been severely abused in the home will need a place to be outside of the home, even if the family is no longer abusing. Some families will need therapy, which is often an excellent adjunct to the child's treatment.

One of the first questions a therapist must explore in treating a child is "what is the level of functioning of the family?" (Bowman, Blix and Coons, 1985; Dell and Eisenhower, 1990; Fagan and McMahon, 1984; Kluft, 1985; Vincent and Pickering, 1988). Couple, family and even individual therapy may be indicated in order to detoxify and stabilize the family of the MPD child.

The authors also suggest that if treatment is going poorly or if there is an unexplained increase in dissociative symptoms, then the environment should be reassessed. They cite a case example from their practice where a severely abusive alcoholic father was no longer in the home, but the child's symptoms were not ameliorating. Upon further investigation, the mother was found to suffer from multiple personality disorder herself, and during amnesic periods was sexually abusing the child.

Hornstein and Tyson caution about the importance that all adults involved in the child's care understand the diagnosis and provide consistent interactions with the child. "The provision of structure, clear limits and nonpunitive interventions for managing problematic behaviors are key elements of ongoing care that must be established prior to the child's discharge. In the hospital, normalization is encouraged. Priority is placed on therapeutic interventions that restore the child's capacity for normal functioning at home, school and with peers, not on uncovering, abreactive work. We find that children who are experiencing some degree of success in their relationships and school performance are better able to tolerate the affect that emerges during uncovering work in therapy. Of course, it is often necessary to work through some aspects of the traumatic experiences to enable the child to experience improved relationships and functioning" (p. 643).

Task 2: Forming Therapeutic Alliance

To form a therapeutic alliance, one must be willing to accept the child's inner experience of separate personalities. The diagnosis is treated with empathy, but in a "matter-of-fact" manner, with clinicians getting to know the al ters' experiences of themselves, of the clinician(s) and of each other. "Our ability to understand the child's inner experience and accept its importance alleviates much of the anxiety that children with MPD have about revealing their multiplicities. Seemingly paradoxically, willingness to accept the alters actually decreases the child's pressure to use dissociative defenses." (Hornstein and Tyson, 1991, p. 642). Routley also speaks about this technique. He comments, "Children are frequently responsive to metaphors and to talking about parts of themselves."

Task 3: Improvement of Functioning and Management of Behavior Problems


The systematic meeting of alters is thought to provide the best opportunity to assess and help the child manage problematic behavior patterns, although hospitalization does not always appear to be necessary. Nursing staff can identify and prioritize behavioral categories that require intervention. Specific competing behaviors are introduced to replace dysfunctional ones. Use of positive reinforcement for the use of new, more functional behaviors, and the use of redirection or "time-out" for destructive behaviors are techniques that facilitate positive change.

Physical restraints are used only when behaviors are seen as harmful to the child or others in the milieu (Hornstein and Tyson, 1991; Weiss, Sutton and Utech, 1985).

The child is encouraged to explore thoughts and feelings, and to gain mastery over his or her dissociation and switching by identifying the thoughts and feelings that occur at those times. Children learn to call on various alters for help during difficult times. Treatment techniques include a variety of approaches such as play therapy (Vincent and Pickering, 1988), supportive therapy (Vincent and Pickering, 1988) and contracting with alters for a commitment to the therapeutic process (Dell and Eisenhower, 1990). Therapeutic techniques lead to the central issue of abreaction. This is the process of discovering the circumstances of the trauma and re-experiencing the trauma in a safe environment. This process allows the child to gain mastery over the experience and leads the fusion or joining of the personalities.

Task 5: Integration of Alters

Integration of alters appears to take place fairly easily in the child MPD who is not as committed to the separation of alters as the adult may be. In addition, MPD children often have fewer personalities than the adult, so integration is made easier by the fewer numbers (Lewis, no date). This process often takes place automatically as a function of abreaction or can be facilitated by the use of hypnotherapy (Dell and Eisenhower, 1990).


Children who have successfully completed therapy will need supportive therapy after integration. They, and their families, will need assistance in dealing with transferring new skills and awareness to functioning in a variety of settings in the child's world (Fagan and McMahon, 1985). Dell and Eisenhower (1990) used post-integration therapy to focus on: 1) additional working through; 2) restoration...
tions of functional boundaries and communication in the family and in the marriage; 3) regular checking of the stability of the integration; 4) continual alertness for the presence of heretofore hidden alters. These latter check-ups will continue during periodic follow-up sessions for the next several years (p. 363).

Treatment for the MPD child, however, is simpler and more rapid than that of the MPD adult (Kluft, 1988; Lewis, no date; Riley and Mead, 1988; Weiss, Sutton and Utech, 1988). Vincent and Pickering (1988) reported therapy for nine MPD children lasting from as little as two weeks to as long as six months.

Current Practice

VCPN contacted 12 clinicians known to be experienced in the treatment of MPD. They varied in credentials and training and included clinical psychologists, social workers and counselors. Six were practicing in Virginia. Five had treated 10 or less cases, five had treated between 30 and 40 cases, one had treated approximately 80 cases and one had treated over 200. However, only four of the clinicians had treated child MPD cases and the highest number of children diagnosed was four. Therefore, it appears that few clinicians are diagnosing and treating child MPD cases.

Five of the clinicians, including one who had treated 30 to 40 MPD clients, were unaware of the instruments such as Putnam's Dissociative Experiences Scale (DES). The other seven used the DES (and/or the Childhood Dissociative Experiences Scale) plus interview and observation. The clinicians talked about obtaining information from family or obtaining a family history. Most relied upon interview data from the client. One person used the Rorschach for diagnosis. Another simply speaks to the alter directly. Use of journaling to check for different handwriting was mentioned, as was videotaping sessions to compare. The MMPI was mentioned by one therapist. One mentioned teacher data as being valuable.

VCPN's conversations with the clinicians suggest there is a great lack of standardization in the diagnostic process. The clinicians also showed little consistency in what indicators or symptoms led them to an MPD diagnosis. Amnesia was cited most frequently as an indicator, as was a history of abuse. Other than these indicators there was little overlap. Some observe extreme changes either within or between sessions. The presence of headaches, prior therapy, frequent switches in careers/jobs, the client hearing voices, distractibility and the client appearing highly suggestible were all cited as diagnostic indicators.

Some clinicians interviewed felt it was important to rule out other diagnoses, such as schizophrenia or manic-depression. Amnesia from drug or alcohol induced blackouts was also mentioned as a possible explanation, as was head injury. The possibility of factitious disorder or borderline personality was raised. In the case of children, the therapist must also rule out hyperactivity, conduct disorder and oppositional defiant disorder. A third of the clinicians interviewed were unable to cite any other potential explanations or diagnosis for symptoms of MPD.

About three-fourths of the clinicians felt there was a critical age range for the development of MPD. The others did not know or felt MPD could develop at any time, including during adulthood. Six cited age ranges prior to age 9, one clinician felt the development of MPD could onset from trauma in adolescence and one felt that trauma in adulthood could cause MPD.

The inconsistencies among clinicians are not unexpected in a new and developing area. Improvements in DSM-IV should assist clinicians by offering better diagnostic guidelines. As information is published and disseminated, diagnostic procedures are likely to become more standardized.

All clinicians were open to the possibility of genetic predisposition to MPD, although only half endorsed genetics as a causative factor. One clinician who recognized the importance of genetics was Dell. He explained, "Not every child is capable of developing MPD no matter what you do to them."

Clinicians interviewed described their clients as "highly intelligent" and "very creative" individuals. Most felt optimistic about the prognosis, rating it as a "good." Treatment time varied with the majority suggesting two to five years, although some clinicians felt eight to 10 years of therapy might be required.

For children, the prognosis was described as much better than for adults. This is consistent with literature reviewed. Dell comments, "If the child is in a safe environment, he or she can begin to get well quickly." Dell adds that therapists of adults should take care to ascertain that the client is not in an abusive situation as well.

VCPN's interview data of a very small sample of therapists suggests that there is a great deal of variation in those treating MPD clients. Diagnostic procedures are informal and even the criteria for diagnosis are varied and unclear. There was a general lack of awareness about the presence of MPD in children and how to detect the syndrome early. Some clinicians were not aware of alternative possibilities or did not routinely screen for alternative diagnoses. A number of clinicians appear unaware of the general assumption in the literature that MPD must be formed by age 8 at the latest.

Conclusion

Multiple personality disorder does appear in childhood. Clinicians, however, may not be aware of the clinical indicators especially as they manifest differently than the adult MPD who fits the specific criteria of the DSM-III-R. Awareness of these differences is important to early diagnosis. Most children identified to date respond rapidly to treatment and thus may avoid years of poor functioning. Stabilization of environment and the use of nondissociative coping strategies will allow a child to move normally through childhood and into adulthood. Clinicians are challenged to learn how to detect and treat this condition.

References Available Upon Request

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**Resource Guides**

**Knowledge Can Heal Resource Directory**

Available from:

B.E.A.M.  
P.O. Box 20426  
Louisville, KY 40250-0426

Soon-to-be-published 140-page listing of survivor publications for those with dissociative histories. Also covers computer bulletin boards, support groups, resource libraries and pen pals. Cost is $14 plus $3 shipping and handling.

**The Healing Hands Resource Directory**

Available from:

Artistic Endeavors Publishing  
P.O. Box 10224-Z8  
Marina Del Rey, CA 90292

This directory lists newsletters for survivors of sexual abuse, ritual abuse and MPD. It offers state-by-state listings of mental health agencies, treatment facilities and support groups for MPD and dissociative disorders. Also, included are audio and video resources and a bibliography. Cost is $43 (non-professional survivors in financial hardship, $23).

**Many Voices/Multiple Choices Resource Guide**

Available from:

Many Voices Press  
P.O. Box 2639  
Cincinnati, OH 45201

This 32-page resource guide has a wide variety of listings. In addition to the expected offerings of books, newsletters and audio/video tapes, one finds health care options, speakers, trainers and consultants. Conferences, workshops and educational materials are included, as well as organizations and support groups. A unique feature is a listing of products made and marketed by trauma survivors. This excel-
In recent years, there have been reports of “ritual” or “satanic ritual” abuse of children, particularly in day-care centers. Accounts by children of adults dressing in costumes, conducting ceremonies around candles, sacrificing animals and engaging the children in a variety of sexual acts shock our sensibilities. These accounts have led the public and professionals to take a more serious look at the subject, not only in day care centers but in cults, religious sects and families. As professionals have attempted to investigate the presence of ritualistic abuse of children, many questions have arisen. Does ritualistic abuse occur? If so, how frequently? How is ritual abuse different from other abuse and neglect? The answers to these questions are not without controversy. First, however, let's address what constitutes ritual abuse.

Definition

Lloyd (1990) suggests that, currently, there is no consensus for a definition of ritual child abuse. He finds that the term has been applied to many different situations, such as bizarre or satanic acts committed on children, group acts of religious worship of demonic powers while perpetrating abuse on children, and psychological intimidation of children which includes attempts to “make them perform acts of religious belief in demonic powers or to abuse other children or animals...”(p. 1). Lloyd suggests that the term “ritual child abuse” has been applied inconsistently.

Lloyd proposes that ritual child abuse be defined as “the intentional physical abuse, sexual abuse or psychological abuse of a child by a person responsible for the child’s welfare, when such abuse is repeated and/or stylized and is typified by such other acts as cruelty to animals, or threats of harm to the child, other persons and animals” (p. 2). This, according to Lloyd, is a definition that focuses on acts and harm to the child rather than on motivation of the perpetrator.

“Group ritual child abuse” and “cult ritual child abuse” are two terms that are often used interchangeably. However, Lloyd suggests that the two terms describe different activities. Lloyd makes the following distinctions between cult ritual abuse and group ritual abuse: Cult ritual child abuse: “the intentional physical abuse, sexual abuse or psychological abuse of a child by persons who are in a religious cult and are responsible for the child’s welfare, when such abuse is repeated and/or stylized and is typified by such other acts as cruelty to animals, or threats of harm to the child, other persons and animals is performed to reinforce the group’s cohesion” (p. 4). Group ritual child abuse: “the intentional physical abuse, sexual abuse or psychological abuse of a child by a group of persons responsible for the child’s welfare, when such abuse is repeated and/or stylized and is typified by such other acts as cruelty to animals, or threats of harm to the child, other persons and animals, and is performed to reinforce the group’s cohesion” (p. 4).

According to Jones (1991), in his review of the literature, it is also important to Finkelhor and Williams (1988) to clearly define ritualistic abuse and make distinctions among types. Their definition of ritualistic abuse is abuse that is “linked to some symbols or group activities that have a religious, magical or supernatural connotation, and where the invocation of these symbols or activities are repeated over time and used to frighten and intimidate children” (p. 164). Finkelhor and Williams propose three subcategories: “true cult-based, where sexual abuse is one component of the child’s total immersion in the cult rituals and beliefs; pseudo-ritualistic, where sexual abuse is the primary activity and cult rituals are secondary; and psychopathological ritualism, where mentally ill adults abuse children while employing idiosyncratic rituals” (p. 164).

Jones (1991), while understanding the need for clear definitions and distinctions for research, believes clinical concerns about definition to be somewhat different. He suggests that the separating of ritual abuse from satanic abuse results in satanic abuse taking on “special and mystical significance” (p. 164). By artificially separating ritual and satanic abuse, the objectivity of practitioners can be jeopardized. He suggests that the fundamental concern of clinicians is to view the impact of the ritualistic activities on the child victims. Jones’ concerns are:

1) Embedding of child sexual abuse within a powerful belief system, especially a deviant one such as satanism, creates significant and long-lasting distortion of the victim’s attitudes, beliefs, allegiances and fundamental personality structure. This can occur to such a degree that adaptive recovery is very difficult;

2) The combination of child sexual abuse with premeditated and sadistic activities appears to result in more serious psychological effects for the victim; and

3) An element of concern for clinicians is that child sexual abuse accompanied by extreme degradation and demeaning of the victim seems to have devastating consequences for the victim’s self-esteem.

Law enforcement regards definition of ritual abuse differently than both clinicians and researchers. According to Kenneth Lanning, special agent with the Federal Bureau of Investigation, and Larry Hardoon, a prosecutor (Think Tank Report, 1990), the criminal justice system focuses on criminal acts against children, not the beliefs of the perpetrators.

Lanning remarks, “My own personal feeling is when someone is abusing a child, committing a criminal act and using his/her own personal belief system to facilitate and enhance it or to rationalize it and justify it, I could not care less what religion or spiritual belief system we’re talking about. Law enforcement must look at all of these cases from a neutral perspective. If the religious belief plays a role we look at it. Labeling the crime with the belief or religion of the perpetrator is counterproductive, confusing and is asking for trouble” (p. 30). Hardoon adds: “It may well be from a clinical therapeutic perspective, distinguishing between ritualistic sexual abuse and ordinary sexual abuse may have some significance. From my perspective as a prosecutor, there is little, if any, distinction to be made in terms of approaching or handling a case” (p. 38). Even so, Hardoon supports efforts to refine definitions. This process, he says, is important because the terms will be used and, thus, should be clarified.

VCNP interviewed ministers and clinicians who had dealt with cases of ritual abuse. They were in general agreement about definitions. In general, they made distinctions between “ritual abuse,” “satanic ritual abuse,” and “cult abuse.” According to those interviewed, “ritual abuse” is a more general term, encompassing the other two. “Cult abuse” was seen as specific to abuse experienced while living in a cult, apart from mainstream society. “Satanic ritual abuse” (SRA) was described as the most severe form of ritual abuse, and sometimes occurring in cults. “Satanic” abuse was seen as focused on specific anti-religious goals and as likely to involve practices
such as cannibalism and human sacrifice. One clinician with considerable experience preferred to avoid the term “ritual abuse,” instead referring to “sadistic abuse.”

This article will use the broader definition proposed by Lloyd. Since literature infrequently adopts standard terminology, VCPN will consider and summarize literature that includes references to “ritual abuse,” “satanic ritual abuse,” “cult abuse,” or “group ritual abuse.”

Incidence

There appears to be widespread disagreement as to the incidence or prevalence of ritualistic child abuse. Many factors, in addition to the definitional problems, contribute to the controversy (Lloyd, 1990).

Perhaps a key factor is the lack of any central agency designated to compile information about allegations. In most states, ritual abuse is not listed as a separate category, thus reports involving ritual abuse are counted in the more usual categories of physical or sexual abuse.

Only recently have a large number of victims related experiences of ritual abuse. Benschoten (1990) reports that from 20 to 50 percent of those diagnosed as MPD reported satanic ritual abuse. However, most accounts have not been validated. The FBI, in a seven-year study, failed to discover any evidence to support claims about a network of groups who ritually abuse children. Perpetrators who admit to such abuse are conspicuously absent.

Symptoms of ritual abuse may appear similar to severe mental illness. Thus, accurate accounts may be disconnected, and conversely, delusions may be accepted as factual. Reliability of recall by adult survivors has been challenged. Recall of memories may occur in a clinical setting when the survivor is under hypnosis. While hypnosis may enhance recall, the procedure may also result in the reporting of an increased amount of false information (Lloyd, 1990; Young, et al, 1991).

While many authors support the idea that ritualistic abuse occurs frequently and that there is a network of cults which engage in ritualistic child abuse (American Humane Association, 1984; Hudson, 1990; Jonker and Jonker-Bakker, 1991; Kelley, 1992; Smith, 1993; Young et al, 1991), there are others who believe that ritualistic abuse occurs infrequently and that the idea of networks of abusers in contact with each other is implausible (Langone and Blood, 1990; Matzner, 1991; Perrin and Parrott III, 1993; Putnam, 1991). These authors suggest that there is a lack of corroborative evidence that cannot be ignored.

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Ritual Abuse

Ken Lanning of the FBI is one of the skeptics. He relates that when he first heard of ritual murder and abuse, he was inclined to believe the accounts. However as the allegations mounted, Lanning began to have a problem with veracity. "I had to total up what was reported to me. I wasn't dealing with a handful of people around the country committing a handful of murders. When I totaled them all up, I was dealing with thousands of people committing tens of thousands of murders and there are no bodies" (Lloyd, 1990, p. 62). Lanning adds, "Fifty thousand children, or humans, are supposedly murdered every year in the country by satanic devil worshippers. Do you know how many murders there are in the entire United States? Approximately 20,000, which means that satanic devil worshippers kill two-and-a-half times as many people as all of the murders put together." (Lloyd, 1990, p. 63).

Perrin and Parrott III (1993), writing in Christianity Today question the lack of defectors from satanic ritual groups. They state, "As we watched the recent confrontation between federal agents and Branch Davidians in Waco, Texas, we could not help noticing that the press seemingly had little trouble locating defectors willing to provide details of the practices of David Koresh and his followers — this despite the fact that speaking out against Koresh could be dangerous. Previous research has demonstrated that defection rates from deviant religions are quite high. Yet when it comes to Satanism, no one has stepped forward to lead us to an ongoing cult or to the remains of bodies used in human sacrifice or to any other physical evidence that supports the stories of SRA." (p. 21)

Michael Langone, Ph.D., is a licensed psychologist who has worked with more than 125 former cult members and their families. He notes that his comments apply to cult survivors, not to satanic groups. Langone is editor of the scholarly Cultiic Studies Journal and has co-authored books about cults. Langone and his co-worker Linda Blood (1991) maintain that there are legitimate cases of ritual abuse. However they state that "many are inaccurately reconstructed 'memories' that therapists believe too readily." (p. 15).

Langone adds that professionals should not let their empathy for genuinely suffering individuals blind their intellects to the possibility that "in some, and possibly most, cases the memories...are greatly distorted or fantasized" (p. 59).

Blood adds another perspective as an ex-cult member, "The problem of Satanism and occult-related violence is not something to be 'believed in' or 'not believed in'...real crimes are being committed...and lives are being damaged through Satanism and occult-related violence just as surely as they are through less exotic forms of criminal behavior" (p. 97).

The literature and interviews revealed two groups of individuals currently receiving treatment. One group are adult survivors. This group appears to be primarily female. Many, but not all, are diagnosed as multiple personality disorder. Many have recalled the ritual abuse only as adults. Few are known to have been reared in a cult and most allege abuse by family members. A second group are children thought to have been ritually abused in day-care centers by babysitters or, occasionally, by a non-custodial parent.

Noticably absent in the literature is the current identification of children who are being satanically ritually abused by parents or family members with whom they live. Since the majority of adult survivors recall ritual abuse by family members, one would expect a large group of children currently being abused in a similar way, who were not previously involved in satanic groups.

Of the ministers and clinicians interviewed by VCPN, only one had worked with children alleging ritual abuse. The rest were serving clients who are adults alleging victimization in childhood.

No one wants to minimize another's terror, beliefs or feelings. No one wants to revictimize courageous survivors by not believing a horrific story. Some people perform gruesome acts of abuse and torture and such atrocities have been documented especially throughout history in times of war or periods such as the Inquisition. Still, there is an obligation to carefully evaluate in an objective manner, especially if criminal or civil proceedings are involved.

Benschoten (1990) maintains that believing the ritually abused client is critical to healing. Yet, she makes a critical distinction between objective reality and experiential truth. The client's memories cannot be accepted as literally accurate, nor can they be dismissed. She maintains that the literal truth is mixed with misperception, suggestion, illusion, dissociation, and induced trance phenomena to form the survivor's memory. Objective reality and experiential truth, thus, cannot be disentangled with certainty.

Chin (1991) summarizes the issues by stating: "It is important that we in the field seek to resolve the issue in an objective and scientific manner. Critiques and claims should focus on the nature, quality and interpretation of the data rather than on the personalities involved. We must not let disagreements on the subject disrupt working relationships, to pit discipline against discipline or to destroy the hard won credibility of child abuse victims, adult or child. There is a great deal at stake here." (p. 178)

Investigation Issues

While controversy over ritualistic abuse continues, allegations are being made and therefore investigations must occur. Investigative procedures are geared toward acquiring evidence for prosecution for criminal activity, or for removal of children from a cult or sect environment. Chris Hatcher, Ph.D., has done extensive research into the formation of cults and violent and criminal behavior in cults (Think Tank Report, 1990). Hatcher suggests that some allegations of ritualistic abuse of children are true.

Hatcher maintains that improved investigative skills can separate false allegations of ritual abuse from the true ones. He comments that while investigations produce a large quantity of interesting psychological and sociological information, little of this information is critical in terms of verifying allegations of ritualistic abuse. Investigators must learn to separate interesting information about cult dogma or ceremonial practices from critical information which connects specific crimes to specific persons" (p. 56).

Hatcher (Think Tank Report, 1990) makes the following suggestions:
1. Any allegation warrants a complete and thoughtful investigation. However, standards for criminal prosecution must be met.
2. Investigative teams should be directed by a single detective or FBI agent who is an experienced investigator, not necessarily assigned full time to sexual abuse cases. Team charts and plans to conduct these very complex investigations can be obtained from the National Center for Missing and Exploited Children. In addition, "prior experience with violent cult cases indicates that the investigative team needs to structure a candid and open discussion of each team member's personal religious views as the investigation begins" (p. 57).
3. There may be a need for a consultant to help obtain specialized background information or offer interviewing assistance. Consultants should be selected who will sign written commitment to confidentiality. Their resumes of investigative work should be verified by a detective or prosecutor who can assess the consultant's potential utility. If the consultant has testified, court transcripts of testimo-
ny should be obtained. An assessment of the consultant’s beliefs about child witness credibility should be undertaken. "Absolute belief or disbelief in child sexual abuse witness credibility is undesirable for any potential consultant" (p. 58). One team member should be designated to have all contacts with a consultant once retained and a level of limits of information that will be shared with the consultant should be established. The team should outline the role they wish the consultant to have, making sure it fits his/her area of expertise and experience. Finally, the team should be certain that the consultant’s contacts with witnesses meet the same legal standards as interviews by the investigative team.

4. Investigations should be person-based rather than group belief based. "The accumulation of information in ritualized sex abuse cases should remain focused upon legally proving or disproving allegations against a specific person. A case should go forward to trial only with allegations, often a limited percentage of the total allegations, which can be substantiated against a specific person" (p. 59).

Rebecca Kemble, M.S., a Registered Art Therapist with Counseling for Growth and Change in Des Moines, Iowa, has over the past eight years, worked with approximately ten children reporting ritual abuse. She offers some observations for CPS workers or police who investigate complaints. "One of the problems for investigators is that there is not sufficient time for them to build a relationship with the child. Children subject to ritual abuse are too frightened and distrustful to disclose what has happened," explains Kemble. Most of Kemble’s cases came to the attention of authorities because of severe physical injuries or sexual abuse. It is as after placement into foster care that the children revealed details of the ritual abuse.

The majority of ministers and providers interviewed felt that there could be alternative explanations for some accounts of ritual abuse. Two providers who were also survivors of ritual abuse were unwilling to consider that any report might be false.

Kemble comments. "To be helpful to children, one must be discerning and not jump to conclusions. The child can relate a mix of fact and fantasy. Investigators need to learn how the child determines what is real and what is not real."

However, before investigation comes reporting. Of the ministers and clinicians interviewed by VCPN, only three had encountered cases of ritual abuse that had been reported to the police and/or to social services. If cases are not reported, then legal and protective action is not possible.

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Ritual Abuse
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Perpetrators

The only data VCPN was able to find on perpetrators involved cases where the allegations were against day-care providers. Data on family perpetrators does not appear to be available.

One of the few published studies with data about perpetrators was a survey of day-care cases by Williams (cited in Lloyd, 1990). In her small sample, the majority of cases (83 percent) involved female perpetrators. Benscheton (1990) in a review of the literature notes that female perpetrators are nearly always reported in day-care allegations. Ritual abuse cases, according to Williams, are also likely to involve multiple perpetrators, unlike cases of sexual abuse that do not contain a ritual aspect.

None of the ministers or clinicians interviewed by VCPN had worked with perpetrators of ritual abuse. From the information available from their clients, most perpetrators were described as disturbed individuals who belonged to a satanic religious group (but were not living in a cult). Women were frequently involved in perpetrating. One therapist who specializes in ritual abuse is Margaret Duke of Richmond, Va. She stated that all of her clients had been abused by women as well as men.

Treatment Issues

A number of resources exist for those who are treating adult survivors of ritual abuse (see Resources, this issue). In contrast, very little was found that concerned treatment of children.

Some limited information is available about children who allegedly experienced ritual abuse in day-care settings. Data must be viewed with caution, since many cases have failed to meet legal standards of proof. Thus samples may contain cases that are valid and substantiated and cases that are invalid. Also, in some of the samples, therapists are reporting case studies, children who are all abused in a single setting, or data from non-random samples.

Children who are ritually abused, compared to those who are abused without ritual, experienced more abuse and more types of abuse. Ritual abuse children also demonstrated significantly more behavioral disturbance than those sexually abused but not ritually abused (Kelley cited in Lloyd, 1990).

Children ritually abused in day care are considered high risk for severe psychiatric problems, especially dissociative reactions and multiple personality (Kelley, cited in Lloyd, 1990). However, to date, no follow-up study of children identified as victims of ritual abuse in day care was found.

Ministers and treatment providers interviewed by VCPN felt that spiritual issues were important to address. Many respondents stressed that spiritual healing was needed along with psychotherapy and behavioral help.

Kemble stating the "tremendous fear index," finds that art therapy and play therapy allow children to express past experiences. "Playing out a scene can allow a child to reveal content, while distancing himself. Once the child plays out a scene, we can examine how it might feel," she explains. Kemble allows the child to lead and notes that therapy with ritualistically abused children requires additional time.

Hudson (1990), based on her treatment of over 30 children, places the length of child treatment at two to three years. After the midpoint, she suggests spacing sessions. She notes that symptoms may appear at later points such as puberty, young adulthood, marriage, when becoming a parent and perhaps at other passages of life.

Virginia's Picture

In 1990, the Virginia legislature created a task force to study ritual crime and mandated that the task force report to the Crime Commission the results of their study. Their report was published in 1992 (see review, this issue).

After doing a thorough literature review, the task force began to gather data about Virginia. A state-wide survey of all law enforcement agencies and school divisions was completed. All 174 chiefs of police, 87 law enforcement sheriffs and 145 school districts received a copy of the survey. Additionally, a random sample of 155 licensed mental health practitioners in Virginia, representing all geographic areas, were polled. To further clarify and verify data, selected respondents were interviewed. Also, the task force received testimony on a number of occasions.

The research evidenced a distinct schism between types of reports and data offered by mental health therapists compared to data offered by other sources. While schools, law enforcement and social services offered specific cases of crime, therapists provided general accounts, frequently years or decades old, derived from client reports. Focus and goals were often substantially different for therapists compared to other groups. Therapists focus on treatment issues, not verification or on prevention and law enforcement issues.

The task force found that definitive documentation of ritual crime was rare. The vast majority of documented cases consisted of minor property crimes (trespassing, graffiti and vandalism) with low damage cost due to being perpetrated on or against abandoned property. Most of these crimes were committed by "dabblers," those who exhibited superficial, usually transitory, interest in a belief system. In no case examined by the task force was there conclusive evidence of homicide in Virginia which could be casually linked to influence of a spiritual belief system or interest in the occult.

The task force concluded that existing criminal statutes in Virginia are adequate to address dangerous conduct which may result from participation in unconventional belief systems. The task force did recommend that the Virginia Department of Criminal Justice Services develop a model curriculum addressing ritual crime for Virginia's law enforcement officers. They also recommended that the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services coordinate continued research efforts relating to the ramifications of ritual abuse in the mental health field. Law enforcement should cooperate with appropriate agencies such as social services when investigating claims of ritual abuse. Finally, the task force recommended that the Virginia Department of Criminal Justice Services establish a definitional standard and review development of a separate reporting category for ritual crime.

SUMMARY

From almost any standpoint, verifiable, accurate data about ritual abuse appears non-existent or at the best extremely unsatisfactory. Without a more accurate and detailed data base, the controversies are likely to continue and will undoubtedly impede the task of offering help and support to survivors who recall ritual abuse.

References Available Upon Request

Commonwealth of Virginia
Department of Social Services
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Department of Psychology
James Madison University
Harrisonburg, VA 22807
(703) 568-6492
FAX: (703) 568-3322

Multiple Personality Disorder from the Inside Out is intended primarily for persons with MPD. However, it could also be useful to therapists, spouses, other family members and friends who wish to be supportive of the person with MPD.

The book contains personal stories contributed by individuals diagnosed with MPD and important people in their lives. They write about the diagnostic process, the pain they experience, their feeling about skeptics in society, and successful therapeutic processes as well as therapy disappointments. They divulge their hopes, discuss the process of unification and talk to their friends and families about their concerns, frustrations and hopes for love and understanding. This book is a powerful and useful tool for anyone who is diagnosed with MPD or is in some way involved in the life of people with MPD.


Klutt’s edited volume contains chapters from major researchers and treatment professionals such as Frank Putnam Jr., Jean Goodwin, Bennett G. Braun and Cornelia Wilbur. Clearly written and concise, this book offers the best overview of childhood MPD available. This book begins with an historical development of recognition and treatment of MPD. Goodwin discusses the current state of credibility problems. Chapters by Wilbur, Braun and Sachs, Frischolz and Putnam discuss the predisposing factors leading to MPD, the role of child abuse and the dissociative mechanism. The transgenerational incidence of MPD is explored and Coons presents a study of children whose parents are diagnosed as MPD. Differences between childhood and adult MPD are discussed in Klutt’s chapter on the natural cause of the disorder. A thoughtful discussion closes the book. Those diagnosing and treating children should find this volume extremely helpful.


“A gift from the open hearts of those who are healing the wounded, everywhere.” This collection of essays, poetry, art, and stories was written by over 50 abuse survivors with MPD. The volume concentrates upon healing. Its message is positive and hopeful as it relates the “triumph of person over pain.”


This is the first self-help manual for MPD. Written by a person with MPD, the book offers an “insider’s view.” Reading through the first three chapters (on recognizing MPD) is like a first person trip through a clinical manual. The examples are rich in everyday detail “Do you find the gas level changes from day to day, even if you haven’t gone anywhere?” “Do you write in more than one handwriting? Do you find clothes, books, cigarettes, alcohol or food you know you didn’t buy?”

The book offers advice in choosing a therapist. Chapters discuss self-healing, internal communication and contracting between personalities. The manual discusses who to tell and how to tell. A chapter discusses whether or not to remain a multiple and other options for recovery and management.


This manuscript started as a suicide note. It is bits and snatches of living and remembering and struggling and being. The volume has no true beginning or end. Madeline O’Conner shares her pain, her questions and a bit of her soul.

United We Stand: A Book for People with Multiple Personalities, by Ellana Gil, Ph.D., 1990, 44 pages, $5.95.

This book was written for people with multiple personalities. The book was written to encourage multiples to see themselves as the “creative, sturdy, smart survivors that they are.” Written in simple language, the book addresses basic questions such as “What is a multiple?” “How do I get to know the inside people?” “How do I get to know the inside people?”

A resource directory is included.

Available from: Launch Press P.O. Box 5629 Rockville, MD 20855 (301) 869-0442 Fax: (301) 869-0621
W.W. Norton and Company, Inc.
500 Fifth Ave.
New York, NY 10110
(800) 233-4830
Fax: (800) 458-6515
This book attempts to appeal to a wide audience of cult victims, their families, clergy, mental health professionals, lawyers, law enforcement personnel. The contributors have an impressive array of credentials and experience.

An introduction offers helpful historical background. The first section on mind control helps the reader appreciate both the tactics used by cults and the damage cults can do to the individual member. The main thrust of the book, however, is on how to facilitate recovery in those leaving cults. The process of leaving, the problems experienced by those who leave and the process of recovery is detailed. Separate chapters discuss assessment, exit counseling and guidelines for therapists, clergy, families and ex-members. Of special interest to readers of VCPN are chapters dealing with children and cults, ritualistic abuse and teen Satanism.

Research

American Family Foundation (AFF)
P.O. Box 2265
Bonita, Springs, FL 33959
(212) 249-7693
The AFF is a tax-exempt research and educational organization founded in 1979 to assist ex-cult members, their families, professionals and scholars. AFF’s professional staff works with more than 100 professionals annually volunteering more than $500,000 in time to research, education and victim assistance activities. AFF offers resources for sale. These include a newsletter, The Cult Observer ($30/year, 10 issues) and the Cultic Studies Journal ($15/year, semi-annual). Free samples of the journal and the newsletter are available upon request. A wide selection of books are sold. Information packets on specific topics are available for a $15 donation. Various reports and journal reprints are offered.

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CHILD ABUSE IN CULTS

It is interesting to find that the literature about cults and the literature about ritual abuse have less overlap than might be imagined. Many of the works about cults contain the assumption that cults exploit and often abuse all members, including children. Yet, those writing about ritual abuse do not appear to be working primarily for even at all with children or adults who used to live in cults. Rather, the ritual abuse is depicted as having occurred toward children living with their families in the mainstream. Indeed, none of the clinicians interviewed about ritual abuse had worked with clients who had known cult involvement.

Definitional Issues

The term “cult” is applied to a wide range of groups. “Cult,” as used in this article, refers to a group or movement that exhibits excessive devotion to a person, idea or object, that uses a thought-reform program to integrate and control members, that induces dependency in members, and that exploits members to achieve the leader’s goals. Cults may be religious, political or commercial (Langone, 1993). While the stated mission may be philosophical, the covert mission is to accumulate wealth and/or power to benefit the leadership (Landa, 1990/91).

There may be many groups which use unethical manipulation techniques that do not meet a definition of cult. Also, groups such as boot camp or religious orders do not qualify as cults because they are explicit about goals, are contractual rather than subtle, and are accountable to outside authorities.

Incidence

There appears to be little incidence data on cults. In the early 1980s the Cult Awareness Network compiled a list of more than 2,000 groups about which they had received inquiries. While not all groups were cults, the network considered 2,000 to be a low estimate on the number of cults active in the country (Langone, 1993). Gaines et al (1984) suggest that, depending upon definition utilized, there are between 250 and 2500 different cults within the United States.

Several studies of high school students in major cities found that from 1 to 3 percent report involvement in groups that could be categorized as a cult. Gaines et al (1984) estimate that 3 million young adults between the ages of 18 and 25 are affiliated with a cult.

Who Joins Cults?

The typical cult member is young (late teens to early 20s), white and middle-class. There are half again as many males as females. Approximately 60 percent have attended college but only 20 percent have graduated. Disillusioned and dissatisfied individuals join the group during periods of unusual stress, duped into thinking that the group will meet their needs emotionally and spiritually. (Appel, 1981; Langone, 1993). A significant number join because of a friend or lover who is a member.

While some writers maintain that few cult members have diagnosable disorders (Langone, 1993), others depict the population differently. Appel (1981) for example, reports that John Clark, M.D., a Boston psychiatrist, divides cult members into three groups. The majority are essentially normal people who turn to cults during times of difficulty. A second category are people with considerable degrees of developmental and emotional problems over an extended period of time. These individuals have a poor sense of identity. Clark’s final category consists of disturbed individuals, although those who are psychotic or schizophrenic are rare.

Markowitz and Halperin (1984), in their review, characterize cult members as individuals who are drawn into the cult because of a sense of inadequacy and a need to establish dependent relationships. Members are willing to sacrifice themselves and their children in exchange for a promise of prominence in the next world. Training to place the group above individual needs can render a parent emotionally indifferent to pain or medical needs of others, including children.

Cult Leaders

Even less data is available on cult leaders. Similarities did appear in the discussions of specific cult leaders. Leaders were described as manipulative, self-centered, controlling and in some cases ruthless. Many were described as “charismatic.” The behaviors described fit a diagnosis of antisocial personality, a category better known to the general public as “psychopath” or “sociopath.”

One source (Landa, 1990/91) offers a profile of cult leaders. According to Landa, a cult leader is usually a dominant male figure, although occasionally there is a pair or “family” of leaders. These males are totalitarian and sexist. Women who gain power within a cult do so
through a "special" relationship with the male cult leader that entitles her to special treatment or favors. Cult leaders gain and maintain power over followers by making absolute claims concerning their own character, abilities or knowledge.

This characterization is especially important to child abuse, as antisocial personalities tend to lack empathy for others. Thus, the leader may require beating or starving of children with little or no concern about the child's well-being. The leader's need for control can lead to rigid rules. A child's expression of rebelliousness, while developmentally normal, may be seen as sin and punished severely. The parents' degree of loyalty to the cult may be measured by their willingness to allow or participate in the abuse of their children. (Landa, 1990/91). Further, members are taught never to question or criticize the leader, and are, as a result, unable to protect children from the cult's child abuse practices (Markowitz and Halperin, 1984).

**Factors Leading to Abuse**

Cults may be at risk to abuse children for several reasons. One is the degree of isolation imposed on members. Cults discourage involvement in outside activities and typically run their own schools. Isolation reduces the likelihood that abuse will be detected or reported, and investigated in the early stages. Isolation also fosters dependence on the leader and decreases the likelihood of questioning authority.

Secondly, many cults define children as public property. By having all members equally responsible for children, relationship bonds to parents are weakened. Some cults sever marital relationships and assign the individuals to new "marriages," a practice that further weakens any sense of family. Sometimes each of the parents and the child may be placed in separate living groups and rarely see each other. Babies may even be taken from their mothers and placed communally. Mothers or parents may be sent travelling to distant cities to recruit members or raise funds and, thus, be parted from their children. Members are taught to view the mission of the group ahead of family (Markowitz and Halperin, 1984).

When parents and children do interact, parents may displace frustration from their life to the child and administer severe punishments. Some members can be described as "impulsive and aggressive" (Markowitz and Halperin, 1984, p. 150). The religious ideology of the cult may support such actions and act as a way to justify the abusive behavior.

Some children appear "targeted" for abuse. For example, Landa (1990/91) notes that children born prior to their parents' membership in the group may be considered inferior to children born after membership, who are considered inferior to offspring fathered by the leader.

The very character of the cult organization and lifestyle predisposes members to abuse. Cults are characterized by totalitarian control by a leader over members' lives, fostering of dependence, prohibition of critical thinking and exploitative working conditions which leave little time for family. Indeed, family ties are frequently actively destroyed (Markowitz and Halperin, 1984).

**Types of Harm**

While any form of abuse is possible in cults, it appears that the most documentation exists around medical neglect leading to death or near death and physical abuse leading to death or near death.

In one of the few systematic surveys of ex-cult members, Gaines et al (1984) interviewed 70 individuals. Problems for children cited by one-fourth or more were lack of immunization, lack of sleep and lack of medical care. Others (Markowitz and Halperin, 1984) note the effects of highly restrictive diets on the child's growth and development, sometimes to the point of death.

Other data comes from case reports. For example, an Indiana cult had a maternal death rate nearly 100 times the state average and a perinatal death rate nearly three times the state average. This group experienced over 100 deaths resulting from treatable conditions such as dehydration, pneumonia, bacterial meningitis, measles and tumors. Cults take advantage of religious immunity exemptions in some state laws to avoid scrutiny or investigation of their practices (Langone, 1993). For a more complete discussion of religious immunity, see VCPN, Vol. 39. While religious belief is protected from governmental regulation, religious conduct is not absolute and no religious group has protection to disregard the law, including laws concerning child protection.

Emotional abuse is common in cults, according to Landa (1990/91). Children's fears may be exploited and used to force compliance to arbitrary standards. There are reports of children being tied, left in dark rooms or cells, left in the woods, confined in coffin-like boxes, threatened and otherwise terrorized.

Physical abuse is common in some cults. Groups may use physical harm to break the child's spirit or teach to child a lesson. Landa (1990/91) offers a number of examples, including daily beatings and burying children up to their necks in dirt. Other children have been disciplined by burning with scalding hot water, by increasing working hours and sleep deprivation. In some groups, underground burial in deep wells is symbolic of death of a "sinful personality and rebirth into a new and submissive disciple" (Markowitz and Halperin, 1984). To try to control the behavior of a two-month-old baby, one group wrapped a piece of wire around the child's thigh and tightened it every time he cried. The wire was tightened to the point that skin had grown over the wire.

In Gaines et al's (1984) survey of ex-cult members, nearly 15 percent cited physical abuse that was life-threatening as a punishment. When allegations of child abuse leading to death were placed against a Michigan cult, 62 children were removed and examined. Approximately 20 percent showed signs of moderate to severe physical abuse. That figure rose to 40 percent for older boys. It was estimated that the chances of a male child in this particular cult group reaching adolescence without physical signs of severe abuse was less than 25 percent (Langone, 1990).

Cults sometimes deliberately kill children. For example, of the 914 followers of Jim Jones who committed suicide or were murdered, 276 were children and teens.

Reports of sexual abuse in cults are apparently common. One cult leader accused of sexually abusing children in his cult had been accused in the past of sexual abuse of children. Members of some cult groups, both adults and children, are encouraged to have sex with one another, including sexual relationships with siblings and children (Landa, 1990/91). One child who entered a cult with her parents at age 9 was "married" at age 12 and by age 15 had been "married" three times (Landa, 1990/91).

**Investigating Cult Abuse**

The first problem may be gaining access to the children in order to interview them or perform necessary medical evaluation. Cults have been known to hide children, sometimes moving them to another state or even another country. Since children are seen as cult property, rather than as belonging with their parents, cults may hold children hostage even if their parents have left the group (Landa, 1990/91).

While some abuses may be very obvious, other abusive practices are difficult to document, or the physical evidence is gone by the time social services are able to

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**Special Thanks to...**

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Continued on page 16
locate the child or children. Interviewing cult children can be a very difficult process, especially if the parents are still members of the group.

The most important objective for cult members is to keep the group intact. It is common, then, for both children and adults to lie to protect the group (Landa, 1990/91). Thus, an indirect approach must be taken. Cult children are typically trained to believe that all non-members are not to be trusted. Further, the child knows that if he or she reveals any secret information, severe punishment will follow.

Landa (1990/91) suggests that the interviewer consult with ex-members of the cult or with cult experts. The investigator should become acquainted with the practices of the cult and any special language used. Landa offers a list of potential questions for the investigator.

Landa cautions that cult children may present as clean-cut, well-behaved, disciplined and polite. If the cult demands that children behave like adults, the child may appear mature. The cult child is indoctrinated into a deviant belief system. Many perceive physical abuse or sexual activity as normal and may not show typical symptoms of psychological trauma or deterioration. A child may be returned to a cult based on erroneous determination that the child’s health, safety and welfare are not at risk.

Cult children who are placed in care, even with non-cult relatives, may feel great attachment to and dependence on the cult and the leader. Cult children who have been isolated may have no prior frame of reference for common experiences. He or she may not have attended school, shopped in stores, been to the movies, seen television or even listened to a radio. Exposure to books may have been limited. Depending upon the practices of the cult, the child may lack exposure to usual American experiences. For example, the child may not have ever seen a doctor or dentist, eaten meat or played with toys. The child may not know how to read or write or be acquainted with money. As a result, the child removed suddenly from a cult may experience a great deal of culture shock and be unable to function well in everyday situations.

The difficulties should not discourage communities from offering the same protection to children in cults as to other children. Children in cults, due to their isolation and indoctrination, are a very vulnerable group of children, dependent upon a totalistic society. They need and deserve our care and concern.

References Available Upon Request

VIDEOTAPES

Space precludes published reviews of video and audio tapes. For review of those below and others, send request to Joann Grayson, Ph.D., Department of Psychology, James Madison University, Harrisonburg, VA 22807.

Cavalcade Productions, Inc.
7360 Potter Valley Road
Lakiah, CA 95482
(800) 345-5530
(707) 743-1168

Identifying Dissociation in Children, 1993, 32 minutes, $175 (Rental $60 plus $4.50 shipping)

Treating Dissociation in Children, 1993, 30 minutes, $175 (Rental $60 plus $4.50 shipping)

Children at Risk: Ritual Abuse in America, 1993, 57 minutes, $39.50

Direct Cinema Limited
P.O. Box 10003
Santa Monica, CA 90410-9003
(800) 525-0000
Fax: (310) 396-3233

After McMartin: Who Walks Point?, 1991, 60 minutes, VHS, $150 plus $5 shipping and handling.

Promise Not to Tell, 1992, 59 minutes, VHS, $195 plus $6 shipping.

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Attention: J. Grayson

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