

ADOLESCENT MPD IN THE NINETEENTH AND EARLY TWENTIETH CENTURIES

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ABSTRACT

Although modern literature refers to cases of adolescent MPD only since 1956, six cases were reported between 1823 and 1926. This article summarizes the case reports of these patients and compares them to modern reports of MPD in adolescence. The early patients were older, were 50% female, and had a maximum of three reported personalities. While some symptoms have remained constant over time, the symptom profiles of early and modern adolescent patients are somewhat different. Early patients frequently switched personalities upon awakening from sleep, had dramatic fainting spells, more complete mutual amnesias, more conversion symptoms, more prominent hazy trances, and less depression. Sexual abuse was reported in two cases but authors were very reticent to discuss it and did not recognize it as an etiologic factor. Even though early authors were neurologically focused, rarely explored psychodynamics, and offered mostly physical treatments, five of six patients had symptom remissions of greater than one year.

INTRODUCTION

Descriptions of multiple personality disorder (MPD) during adolescence are now appearing in the literature with increasing frequency. The first case of the "modern" era was published in 1956 (Alexander), but only three more reports (Gruenewald, 1971; Horton & Miller, 1972; Wagner & Heise, 1974) appeared prior to the past decade. Between 1981 and 1990, thirty-three adolescent MPD patients were reported (Walters, 1981; Fagan & McMahon, 1984; Bowman, Blix & Coons, 1985; Dean, Dean, Burnett & Way, 1985; Kluff, 1985; Lovitt & Lefkof, 1985; Dell & Eisenhower, 1990). The only two series of adolescent MPD patients are those of Kluff (1985) who provided a general description of sixteen patients, and Dell and Eisenhower's (1990) more detailed description of the symptoms of eleven patients. If Kluff's sixteen patients and the three patients (Dean, et al., 1985; Lovitt & Lefkoff, 1985; Wagner & Heise, 1974) who are only briefly described are excluded, twenty-one modern cases of MPD are available for analysis.

To date, no literature review of MPD in adolescence has

mentioned cases prior to 1956. The nineteenth and early twentieth century literature does, however, contain six case reports of patients between ages thirteen and nineteen who suffered from MPD (Dewar, 1823; Mayo, 1845; Barrett, 1887; Burnett, 1906; Gordon, 1906; Goddard, 1926). In addition, Carlson (1989) mentions Elliotson's 1840 report of "double consciousness" in a sixteen-year-old girl, but the report is too brief to permit analysis.

The purpose of this paper is to call attention to early cases of MPD in adolescents, to provide an overview of the clinical characteristics, treatment and outcome of these patients, and to contrast them with modern adolescent MPD patients. These cases illustrate the attitudes of early practitioners toward MPD and provide a demonstration of how the field of dissociative studies has progressed.

CASE REPORTS

Since few readers will have ready access to the early case reports, a brief summary of the six cases is presented below. Table 1 provides a summary of some of the clinical characteristics of these patients. Table 2 presents the frequency of these same symptoms in various types of reports of modern adolescent MPD patients. Modern reports vary greatly in completeness and intent, so reports of similar completeness are grouped together. In all case reports, the absence of a symptom may be due to true clinical absence, lack of recognition by the author, or omission from the report. Thus, trends in the patterns of symptoms are more meaningful than the exact frequency of these symptoms.

Dewar's (1823) patient was a sixteen-year-old Scottish servant girl with two personalities who were separated by complete two-way amnesia. She presented with attacks of drowsiness leading to trance states during which she talked, exhibited alterations of skills, imagined herself to be an Episcopal clergyman or to be in another city, rode a stool like a horse, engaged in housework, and appeared to be unaware of her surroundings. She exhibited diminished visual acuity and complained of headaches prior to her trance states. She was sexually assaulted after her treatment began, but no mention is made of prior abuse. Her trance states disappeared after approximately six months of non-specific treatment and just after the onset of menses. Dewar felt she had somnambulism and her case exemplified the influence of the uterus and puberty on the workings of the mind.

In 1845, Mayo briefly reported an eighteen-year-old single English girl with two personalities separated by complete two-way amnesia. She presented with various somatic

TABLE 1
Clinical Characteristics in Early Adolescent Case Reports

Characteristics of Patients	Dewar 1823	Mayo 1845	Barrett 1887	Burnett 1906	Gordon 1906	Goddard 1926	Total/ Mean
Age of Patient	16	18	17	16	19	19	17.5
Sex of Patient	F	F	M	M	M	F	50% F
Number of Personalities	2	2	2	3	2	3	2.3
Dramatic clinical presentation/falling	•	•	•	•	•	•	6
Somatic symptoms	•	•	•	•			4
Two completely separate memory systems	•	•	•				3
Did not know family or friends	•	•	•	•	•		5
Affective symptoms				•			1
Conversion symptoms	•			•		•	3
Drowsiness/hazy states with switches	•	•	•	•			4
Sleep as switch mechanism	•			•	•	•	4
Childhood onset of some symptoms				•		•	2
One year cessation of symptoms	•	•	•	•		•	5
Characteristics of Case Report							
Focus on physical or neurologic causes	•		•	•	•	•	5
Epilepsy considered as a cause			•		•		2
Acknowledgment of psychodynamics						•	1
Abuse or trauma mentioned	•					•	2

complaints and was noted to switch personalities when pressure was applied to the vertex of her head. Her alter was more spirited, intellectual and physically active, did not recognize family or friends, and did not observe the patient's usual deference to those of higher social rank. Although no abuse or trauma are mentioned, Mayo vaguely mentions "circumstances of misconduct in her relatives." She did not respond to "medical measures" but her switches gradually disappeared and the primary state became "permanent." Mayo interpreted her illness as normal and abnormal states, the latter induced by trance.

Barrett's (1887) patient was a seventeen-year-old English boy with two personalities who were completely separated by two-way amnesia. He presented with fits of cataleptic rigidity and unresponsiveness, followed by the appearance of a middle-aged alter who did not recognize family or friends, had different handwriting, did not acknowledge his own legal name, exhibited different habits and tastes, had better academic and musical skills, and sang and played in a wild excited state. His switches to the alter occurred with drowsiness, but switches back to the host came with groans and rolling about, followed by getting up and continuing the conversation or activity he was engaged in before dissociating into the alter. His symptoms continued to be manifest every few days for two years, and then disappeared when he was sent abroad for a change of scenery. His only known residual symptoms were psychosomatic pains later in life. No mention is made of traumatic or abusive experiences. Barrett felt his patient had two hypnotic memory chains consisting of "pre- and post-epileptic hallucinations" and was "in some ways intermediate between ordinary instances of post-epileptic hallucinations and alternating personalities."

In 1906 Burnett reported a sixteen-year-old American boy who had suffered from headaches, stomach pains, dazed states and seeing glimmering lights since childhood. At age fifteen he had brief bouts of depression, attacks of paralysis and muteness, and episodes of sudden unconsciousness which resulted in injuries from falling. He began to switch into clearly different states upon awakening from sleep. Other switches occurred gradually, with resultant hazy states. In the most clearly identified alter state, he did not know friends, home, or family except for a vague acquaintance with his mother, whom he threatened with a knife. While the host was a polite young man who aspired to the religious ministry, this alter was a tough, angry male whose threats to kill his doctor resulted in the use of physical restraints. In an alter state (which probably was different from the first and most clearly identified alter state), he was unable to name objects. The host had complete amnesia for the existence and activities of the alters until later in treatment when his amnesia diminished and he took on some of the characteristics of the angry alter. This was accomplished during inpatient treatment by utilizing forcible suggestions to establish memory links between the host and angry alter. Over the next two years no episodes of dissociation were noted. No mention is made of traumatic or abusive experiences.

Gordon's (1906) patient was a nineteen-year-old married American man who presented with complete amnesia for orders at work but, when confronted, gradually acquired

hazy memories for these events. Eighteen months later he began to hear internal conversations and gradually became aware of an antagonistic internal being who opposed his actions, stayed away from home for days at a time, engaged the host in long struggles for control, and at times gained executive control of the body. The host also sensed a third part that he felt controlled the actions of himself and the antagonistic alter. Switching took place in various situations — usually gradually, but also after sleep and suddenly while awake. His symptoms responded only briefly to anti-epileptic medications and remained problematic after eight to nine years. Gordon felt the patient's illness was an "epileptic psychosis," that his belief in two egos was delusional, and the voices were hallucinations caused by seizures in the sensory centers of the brain. No mention is made of abuse or traumatic experiences.

The most modern of the early cases (Goddard, 1926) is an extensive description of a nineteen-year-old single American woman with conversion symptoms of paralysis, blindness, deafness, and anesthesia. Childhood somnambulism was reported. Switches between the adolescent host and a four-year-old alter began sometime during adolescence. The host (Norma) was a quiet, polite, generous, hard-working young woman who was amnesic for the alter. The child alter (Polly) exhibited the conversion phenomena, was boisterous, emotionally demonstrative, impatient, willful, and illiterate. She spoke with crude grammar, had a childish voice, and made up a new name for everyone she met. She had awareness of the host but little knowledge about her. Switches occurred daily and were nearly always with episodes of sleep during which she struggled physically as if fighting off an attacker. Some switches occurred with faints during which the host fell "as if struck dead." By the time she was age eleven, this young woman had sustained the deaths of four siblings, including her twin sister. The deaths of her parents occurred when she was sixteen and seventeen years of age, respectively. She reported separation from her surviving siblings, emotional abuse by relatives who kept her, and paternal incest at age fourteen. A third ego state emerged, exhibited amnesia for the past three years, and was dismissed by Goddard as simple amnesia.

Goddard felt that this patient's multiple losses led her to retreat to a daydream world in which she wished for a home and family. He believed the incest reports were a transference hallucination. She was treated with hypnosis, age progression, suggestions of increased memory sharing, and attempts to suppress alter states. Gradual merging of Norma and Polly occurred and the patient had no known amnesic episodes or switches over a two-year follow-up period.

DISCUSSION OF EARLY CASE REPORTS

Age, Sex, and Number of Personalities

The mean age of these early patients was 17.5 years, considerably older than the mean (15.0) for modern adolescent patients. The youngest of the early patients was age sixteen, but only 38% (8/21) of modern patients are sixteen years or older at diagnosis. Half of the early patients were female, a much lower proportion than in modern reports, in

TABLE 2
Clinical Characteristics of Modern Adolescent Case Reports

Characteristics of Patient	Complete ¹ Reports	Brief ² Reports	Dell 1990	Kluft 1985	All Cases
Number of patients	7	3	11	16	37
Mean age in years	15.5	15.3	14.7	NR	15.0
Age range	14 - 17	14 - 16	12.3 - 18.8	NR	12 - 18
Sex	5F, 2M	3F	7F, 4M	12F, 4M	73%F
Mean number of personalities	3.7	3.5*	24.1	NR	14.9
Range of personalities	2 - 7	3 - 4	5 - 69	NR	2 - 69
Dramatic clinical presentation/falling	5	3	4	4	16/37
Somatic symptoms	3	1	6	NR	10/21
Two completely separate memory systems	NR	NR	NR	NR	0
Did not know family or friends	NR	NR	NR	NR	0
Affective symptoms	4	NR	9	NR	13/18
Conversion symptoms	2	NR	1**	NR	3/18
Drowsiness/hazy states with switches	1	NR	10****	NR	11/18
Sleep as a switch mechanism	0	NR	NR	NR	0
Childhood onset of some symptoms	2	NR	11	NR	13/18
One year cessation of symptoms	3	NR	3****	NR	6/18
Characteristics of Case Report					
Focus on physical or neurologic cause	0	0	0	0	0/37
Epilepsy considered as a cause	1	0	0	0	1/37
Acknowledgement of psychodynamics	7	3	11	16	37/37
Abuse or trauma mentioned	6	NR	11	NR	17/18

¹ Alexander, 1956; Gruenewald, 1971; Horton & Miller, 1972; Walters, 1981; Fagan & McMahon, 1984; Bowman, Blix & Coons, 1985.
² Wagner & Heise, 1974; Dean et al., 1985; Lovitt & Lefkof, 1985. * Based on two cases. ** Personal communication, J.W. Eisenhower, December 1990.
 *** Described as "dazed states." **** Three patients integrated, three others improving.
 NR = Not reported. Determination of the presence of the symptom is not possible due to the brevity or focus of the case report.

which 73% are female. The older age of the early patients, coupled with earlier emergence into adult roles in the nineteenth century, results in the early adolescent patients having more social resemblance to adult patients than is seen in modern case reports.

The mean number of reported personalities also differs markedly between early (2.3) and modern (14.9, $n=20$) reports. No early patient had more than three personalities and the third personality of Burnett's (1906) and Goddard's (1926) patients were not recognized by those authors but are discernible from their descriptions of clinical phenomena. In contrast, only four of twenty modern adolescent patients have three or fewer personalities. The number of personalities seen in both the early and modern adolescent reports is similar to adult cases from their respective eras. The lower mean age of adolescents and the higher number of reported personalities of all modern patients likely reflects more diagnostic sensitivity for MPD by modern authors.

Psychodynamics

While modern reports of MPD refer frequently to the symbolic significance of alters and the psychodynamics of their creation, the early literature is markedly devoid of such a focus. It is only after analytic theory became known that references to the psychodynamics of alter states occur. Thus, the dynamics behind these patients' symptoms must be inferred from descriptions of their symptoms and life circumstances when the illness presented. Although modern readers can only speculate about detailed psychodynamics, some interesting trends are apparent.

One patient illustrates a wish to escape the restrictions of social class or youth by forming an older personality (Barrett, 1887). Two had alters that did not feel the need to conform to the behavioral norms imposed by their social class or sex (Dewar, 1823; Mayo, 1845). Barrett's patient exhibited the onset of symptoms with the stress of competing for a scholarship to Cambridge. His symptoms successfully delayed entry into college for two years, but also provided an adult identity that looked back on imaginary youthful experiences and did not need to face the transition to adulthood.

The alter of Dewar's patient gave her a more important identity than that of a female servant. Her symptoms, which became prominent after a reprimand from her mistress, included acting as a minister — an occupation forbidden to women at that time. In her alter state she was able to be more physically boisterous than was acceptable for a girl on the verge of womanhood. It is not clear why her symptoms ceased with puberty, but the reality of her more adult status may have resolved the conflict she felt over the approach of adulthood.

The alter personality of Mayo's patient also provided an escape from her subservient social position. This young woman was the beneficiary of "kindness and instruction" from "ladies" in her town, but while in her alter state she did not know her family, acknowledge her "true position," or exhibit "respectful manners" toward the ladies. Her alter state also allowed her more intellectual attainment.

Nineteenth century society, particularly in England (from which these three cases come), was much more conscious of

social class and provided fewer opportunities for upward social mobility. Women, in particular, were forbidden entry into many professions until later in that century. The three cases which illustrate a possible wish to escape class or gender-based restrictions are the earliest cases and all come from the nineteenth century. At that time persons in late adolescence found their career opportunities limited by the social class of their families. In the face of such societal restrictions, the formation of older or less socially conforming personalities is understandable.

These "escape dynamics" may explain the onset of symptoms at the end of adolescence when these patients faced the assumption of adult roles from which they perceived no escape. These patients were older than their modern counterparts; most of them were on the threshold of emergence into adult roles. Barrett's patient was on the verge of entry into college. Burnett's patient became ill just after taking an examination for entry into the ministry. Internal conflict over hostility toward authority figures (mother and doctor) is prominent in his presentation, indicating that he may have felt conflict over identifying with such figures as he entered the ministry. Similarly, Gordon's patient exhibited struggles over responsibility on his job and intimacy in marriage — both issues associated with entry into an adult role.

Like modern adolescent MPD patients, these early patients exhibited conflict over expressing hostility toward adults, particularly family members and other societal authorities. In five of the six early cases the patient did not recognize family members. This is infrequently reported in modern cases. Its presentation in early cases may be due to their higher incidence of hazy trance states and of two completely separated memory systems. The lack of recognition of family may also signify both the wish to escape from being part of the family as well as covert hostility toward them. Overt threats or attempts to harm others occurred in only two of the early patients (Burnett, 1906; Gordon, 1906), both of whom were male. In contrast, violence or threats are mentioned in four of Dell's (1990) eleven patients and in Wagner's (1974) patient, all of whom were female. It is unlikely that the socialization of girls in the eras of these early cases would have left violence open as a behavioral option. Obviously, our modern situation is different. It is difficult to say if anger about abuse is the source of hostility in these early cases because abuse is so rarely mentioned in these reports.

Clinical Symptoms

Nineteenth century psychiatric and neurologic literature is full of cases of conversion as a manifestation of "hysteria." Three of these six early cases report conversion symptoms — paralysis, visual alterations, and aphonia (Burnett, 1906), visual alterations (Dewar, 1823), and paralysis, blindness, deafness, and anesthesia (Goddard, 1926). Conversion phenomena continue to be a part of adolescent MPD, but now occur less frequently. Two (Gruenewald, 1971; Horton & Miller, 1972) of the seven modern complete case descriptions mention conversion, and one of Dell's (1990) eleven patients exhibited conversion symptoms (Eisenhower, personal communication, 1990). Thus, the incidence of

conversion in early (50%) and modern (3/18, 16%) cases indicates that this symptom remains a feature of MPD, but its frequency among MPD patients has decreased as conversion has become less common in the modern era.

Conversion symptoms are one example of the dramatic presentation of MPD in these early cases. Such a dramatic presentation (conversion symptoms) is also found in the one nineteenth century MPD report in a child (Fine, 1988). Other dramatic symptoms distinguish all six of the early cases from more modern ones. "Fainting" with physical falling occurred in three cases (Burnett, 1906; Gordon, 1906; Goddard, 1926), sometimes with considerable injury. Thrashing about during sleep was reported in two cases (Barrett, 1887; Goddard, 1926), and prominent states of insensibility or unresponsiveness occurred in at least three cases (Barrett, 1887; Goddard, 1926; Mayo, 1845). Two patients exhibited wild behaviors such as singing, dancing, crying, incoherent laughing and speech, dancing on a narrow bridge, and riding a stool as if it were a horse.

It is possible that early cases report more dramatic symptoms because clinicians were only able to identify obvious symptoms of dissociation. Another explanation is that dramatic presentations occur in adolescent MPD patients of all eras because they possess less behavioral control than adults. Modern adolescent cases certainly report high rates of dramatic behaviors, but only one patient (Horton & Miller, 1972) fell into faints. In twenty of thirty-seven (54%) modern cases, adolescents exhibited dramatic symptoms such as suicidal behaviors, threats of violence, elopement, or unacceptable social behaviors. The rate of these behaviors may easily be higher than 54% because the description of symptoms was incomplete in many reports. This author suspects that the rates of dramatic presentations have not changed greatly over time, but that cultural changes have resulted in the use of a different set of symptoms in such presentations.

Early cases of adolescent MPD exhibited different patterns of amnesia than do modern patients. All of the early patients exhibited amnesia, but half of them had a pattern of two completely separate memory systems with complete two-way amnesia (Barrett, 1887; Dewar, 1823; Mayo, 1845). The primary personality of Barrett's patient was even noted on re-emerging to resume the conversation or activity he had been engaged in prior to switching, even if several weeks had passed. In the cases of mutual amnesia, repeated switching occurred between the same two personalities. Similarly, early reports of adults with MPD describe few personalities and mutual amnesias. Given the sharp rise in the number of alters reported in modern cases (Dell, 1990), it is quite possible that other alters existed in these early patients, but the only personalities that were recognized were those with the obvious amnesia for the host. Complete two-way amnesia is seldom a presenting symptom in modern adolescent patients, but it can occur between pairs of personalities in patients with many alters.

Early patients switched personalities in ways that are seldom mentioned in modern reports. Periods of drowsiness or hazy states with switches are noted in four early cases (Barrett, 1887; Burnett, 1906; Dewar, 1823; Mayo, 1845) but

are noted infrequently in modern reports. Only Horton and Miller (1972) make definite mention of this means of switching. Dell (1990) reports "dazed states" in ten of eleven patients, but it is not clear that these states resulted in or were manifestations of a switch of personalities. In contrast to modern literature, four early cases report sleep as a mechanism by which switches occurred (Burnett, 1906; Dewar, 1823; Gordon, 1906; Goddard, 1926). Patients were described as retiring for the night to awaken the next morning in a different personality. Other patients were noted to switch upon awakening from a nap. While it is possible that unresponsiveness during trance states was mistaken for sleep, one report (Dewar, 1823) clearly distinguished trance states (with positive and negative hallucinations and a glazed gaze) from switches which occurred after naps. For Goddard's (1926) patient, switches without natural sleep or falling into a dead faint were quite rare. Consequently, Goddard used the suggestion of sleep to try to switch the patient back to her older personality. This had only fair success since the four-year-old alter, like modern four-year-olds, objected to taking naps! There is no ready explanation for this pattern of switching in early cases, but it is not mentioned at all in modern adolescent case reports.

Affective symptoms are notably absent in early literature, being reported only by Burnett (1906). Nine of Dell's (1990) eleven patients and four of the seven single modern case descriptions mention affective disturbance, a much higher rate (61%) than in the older literature (16%). Again, the reason for this difference is not clear, but it is possible that early practitioners did not note and register depressive symptoms, did not recognize dissociation in depressed patients, or that patients with obvious dissociation did not exhibit much depression because their clear amnesic boundaries protected them from dysphoria.

Psychosomatic symptoms occur with striking frequency in both modern and early cases of adolescent MPD. Such symptoms are prominent in four of six early cases and occur in ten of the twenty-one modern reports that include details of symptoms. Early cases report headaches in two patients and other somatic symptoms in two others. Modern cases report headaches in eight patients, and vague somatic complaints in two others. Headaches are a well-known sign of internal struggle or impending dissociation in MPD patients, and appear to be a symptom which has endured as a frequent manifestation for more than a century.

The Nineteenth Century Neurologic Focus

The nineteenth century was a time when clinicians emphasized neurologic reasons for psychiatric symptoms. Accordingly, five of the six early case reports focus on neurologic or physical causes as explanations for the alternating states, even when these states were clearly identified as dual personalities. The two cases which postulate an epileptic etiology describe personality states as hallucinations caused by "epileptic psychosis" (Gordon, 1906) or "pre- and post-epileptic hallucinations" which formed a separate memory chain (Barrett, 1887). In neither case is much evidence of seizure activity mentioned in the case description. Gordon postulated a separate hypnotic memory result-

ing from epileptic states and felt his patient's internal voice was a hallucination caused by seizures in the sensory centers of the brain. Barrett was aware of case reports of "alternating personalities" but emphasized epilepsy as the cause of his patient's symptoms. His final explanation incorporated both ideas: he described his patient as "in some ways intermediate between ordinary instances of post-epileptic hallucination and alternating personalities."

Burnett (1906) and Dewar (1823) do not provide a specific neurologic explanation but focus heavily on descriptions of neurologic abnormalities such as conversion symptoms or other physical symptoms such as a stomach pain and headaches, a gastrointestinal bleed, constipation, halitosis, and the lack of a pupillary light reflex. Dewar's report is the earliest description of adolescent MPD in the nineteenth century and emphasizes the classical medical explanation that the uterus and the onset of menses affected the female mind in an irritating manner that produced the patient's symptoms. Even though a sexual assault was documented during the patient's treatment, the focus on the uterus as a source of symptoms had a purely physical emphasis. Sexual abuse was not considered as a cause of difficulties.

As late as 1926 Goddard, whose case is clearly the most psychodynamically oriented of these early reports, attempted to provide a neurologic explanation for his patient's MPD. He felt separate personality states were different phases of sleep walking (his patient is the one who regularly switched personalities after sleeping). He also hypothesized that amnesic barriers were due to a combination of increased synaptic resistance and a nervous system whose energy was insufficient to overcome this resistance. While his explanation may sound overly mechanical and simplistic to modern readers, modern investigators still have insufficient neurologic data to disprove his hypothesis.

In modern case reports of adolescent MPD patients, virtually no emphasis is placed on physical or neurologic diseases as a cause of the MPD. Instead, as seen below, the role of physical and sexual abuse is clearly highlighted—a situation quite the opposite of early cases.

Sexual Abuse

Regardless of the age of the patients, modern reports of MPD clearly emphasize the role of child abuse and other traumatic experiences in the etiology of this illness. Sixteen modern case reports of adolescent MPD either mention childhood abuse or refer to suspected abuse. Nearly all the case reports that omit mention of abuse are among those which provide the briefest case descriptions or are focused on psychological testing data. Where abuse is absent, as in one of Dell's patients, the existence of trauma is mentioned. In modern reports, frank mention is made of sexual abuse and details are often provided in clinical vignettes.

The early literature provides a stark contrast to the open discussion of sexual abuse found in recent reports. In four cases, the presence or absence of any abuse or trauma is simply not mentioned. The two cases which mention sexual abuse are illustrative of the reticence of early physicians to discuss this topic. Both cases (Dewar, 1823; Goddard, 1926) were reported in English, but revert to Latin to discuss

sexual matters.

Dewar's paper is a second-hand report to the Royal Society of Edinburgh about a communication received from the treating physician, Dr. Dyce. During her treatment, this sixteen-year-old female patient was raped. Dewar mentioned that the particulars were "clothed in the Latin language" in the original communication. His choice of terms nicely illustrates the nineteenth century desire to clothe the subject of being unclothed. Unfortunately, Dr. Dyce also thought it "not at all necessary" to relate any details of the sexual assault. Even though he recognized that symptoms worsened after the rape, he made no effort to inquire about other incidents of abuse or their possible connection to the onset of the patient's symptoms.

The other report, that of Goddard, occurred in 1926 after analytic theory was well-known. Both of this patient's personalities repeatedly reported paternal incest and never once retracted their story. Goddard recognized that she was re-experiencing this event in her restless sleep and he was tempted to believe her, stating that "there were many things to make one believe that it was a genuine experience and not an hallucination." Unfortunately, his reliance on theory overturned his clinical observations. He termed her experience imaginary, attributed it to transference, and would only describe it in Latin: "The *vita sexualis* was manifested through a *hallucinosus incestus patris*."

Goddard's conclusion was based on the prevailing belief that in hysteria a hallucination of incest was the rule. He also disbelieved his patient because she had little anatomical knowledge and had not reported the incest until age nineteen, five years after its occurrence. Goddard's report nicely demonstrates his era's lack of knowledge about the norms of behavior for sexual abuse victims as well as the negative effects of an over-zealous application of analytic theory on the recognition and proper treatment of the psychological sequelae of such abuse.

Treatment of Early Patients

Physicians have always designed treatments which reflect their theoretical approach to the etiology and pathophysiology of the disease state in question. Accordingly, in modern case reports of adolescent MPD, treatment is heavily slanted toward insight-oriented psychotherapy designed to dismantle amnesic barriers and resolve conflicting feelings about traumas. Medication is seldom, if ever, mentioned and plays a very minor role in treatment because physical disturbances are not felt to play an important etiologic role in MPD. The earliest practitioners followed their neurologic and physical emphasis and offered more somatic treatments. It is only in the two most recent of the early cases that a psychological focus becomes apparent.

The treatments offered these early adolescent patients were generally non-specific and reflected the general approach of nineteenth century Western medicine. In four cases (Barrett, 1887; Burnett, 1906; Dewar, 1823; Mayo, 1845), non-specific physical treatments were used. Pressing on the head, immersing hands in cold water, and exposure to cold wind were used to aid switches back to "normal" states. Burnett, like modern practitioners, used restraints to

prevent violence. Non-specific psychological measures included reprimanding the patient for irresponsibility, sending the patient overseas for a change of scenery, avoiding rewarding the symptoms with attention, and clearly defining consequences for behaviors. While the intent of limiting acting-out behaviors is similar to that of modern treatments, the technique used by Burnett would hardly suit today's clinical atmosphere. As his restrained patient struggled to try to strike him, Burnett assumed a threatening pose and told him, "You attempt again to hit me, and I will hit you so hard you will not know your face." His technique was, however, eminently successful in preventing further violence.

In keeping with the physical and neurological focus of the times, medications were offered patients in three cases (Burnett, 1906; Dewar, 1823; Gordon, 1906) and possibly were part of "medical measures" offered by Mayo (1845). As would be expected, antiepileptic medications and emetics had no lasting effect, but they apparently exerted a placebo effect and suppressed symptoms for short periods in several patients.

Two practitioners exhibited more sophisticated psychological approaches that directly addressed the patient's symptoms. Not surprisingly, these are the most recent of the early cases, so treatment likely reflected a more sophisticated psychological understanding. Burnett (1906) and Goddard (1926) both successfully suggested that memory links be established between alters. Burnett used forceful "commands" in rapid-fire succession while physically assuming an authoritative posture; he then sent his patient out for a walk. Over the next four days the patient reported the return of many memories of actions by his violent alter. This patient's symptoms disappeared and did not recur over two years of follow-up.

Goddard's report is the most modern (1926) and is the only one to report a succession of treatment approaches or the use of hypnosis. Goddard first tried suggesting to the four-year-old alter (Polly) that age progression would occur. This was successful for a short period, but regression occurred. Concluding that this method was a failure, Goddard tried hypnosis to induce sleep in hope of switching the patient back to the adolescent alter (Norma). Serendipitously, Goddard found that hypnotically induced sleep resulted in Norma acquiring some of Polly's memories. Goddard's next strategy was the use of hypnosis to keep Norma in control and suppress Polly. Like modern practitioners, he found this did not work for long and incurred objections from Polly. Abandoning this method, Goddard finally moved to the strategy used by modern therapists, use of hypnosis to restore the memory of each alter to the other and to "blend" the two personalities. This was successful. Amnesia and switches ceased and the patient took on the characteristics of both Polly and Norma. She remained symptom-free over two years of follow-up. Unfortunately, Goddard did not help her resolve her feelings about incestual experiences and he mistook a third ego state for simple amnesia.

Treatment Outcome

Overall, the early patients fared surprisingly well, at least in the short run. As detailed above, the two patients who

received more specific psychological treatment exhibited resolution of amnesia and no further switches between alter states over two years of follow-up. Three of four patients who received only non-specific treatments improved (Barrett, 1887; Dewar, 1823; Mayo, 1845). Amnestic periods and obvious switching ceased and did not recur during follow-up periods of at least a year. Gordon's patient fared less well. Over eight to nine years he continued to experience struggles with a hostile alter. His only improvement was the replacement of amnesia by partial consciousness of his alter.

How can we explain such outcomes without treatment that we would consider adequate? First, temporary disappearance of symptoms is well-known in MPD. Switching can cease for years while alters remain quiescent. Thus, cessation of symptoms should not be mistaken for cure. Second, follow-up periods were not long enough to say with certainty that the patient was cured. Third, we do not know the complexity of these patients and have little knowledge of the existence or extent of abusive experiences. Thus, we cannot say they were as clinically complex or as seriously ill as modern adolescent MPD patients. They may indeed have been less traumatized and had fewer alters, although this author thinks it more likely that additional alters were overlooked because of ignorance about the nature of the disorder. Because the normative expression of MPD in nineteenth century literature was dual personalities, it is unlikely that physicians would have searched for more alters as modern therapists do. It is equally unlikely that early physicians would have recognized the subtle signs of MPD that allow modern therapists to discern the presence of alters who do not exhibit frank amnesia or who do not have well-developed identities. Fourth, these patients may have done well because some of their symptoms were related to the transition to adulthood. After they left adolescence they may not have needed the symptoms to manage their psychological conflicts. For some of them, the transition to adulthood could have meant escape from home, a place where they may have been abused. With the cessation of trauma, the need for these symptoms may have ceased. Again, this does not signify cure of the dissociated state, but may echo modern findings that progress occurs best when the youthful patient is removed from the abusive situation.

SUMMARY AND CONCLUSIONS

Overall, early case reports of MPD in adolescents reveal older patients, more male patients, and markedly fewer reported personalities than are seen in modern reports. Recognition of symptoms in childhood was rare in early reports. Except for the sex ratio, these differences can be attributed to less clinical knowledge about MPD, leading to later diagnoses and lack of recognition of more subtle signs of alters.

The presenting symptoms of early patients were more dramatic and fit the more hysterical slant of nineteenth century neuropsychiatric symptoms. Although conversion phenomena persist at a lower frequency, falling into dead fairs, prolonged hazy trance states, and mutual amnesia with lack of recognition of family members are rarely report-

ed now. Some of the symptoms of modern patients—depression, threats of violence, suicide attempts, elopement, and antisocial behaviors—are representative of the tone of modern psychiatric reports on adolescent psychopathology, but are seldom seen in early reports. It appears that adolescents of both eras exhibited symptoms which are more in line with the overall cultural milieu of their times. In addition, both groups exhibited characteristics of MPD (such as number of personalities and sex ratios) which are similar to those of the adults of their eras. The number of observed personalities is likely an artifact of differential methods of exploring and reporting MPD, since the literature of any era only contains the observations which authors of that era were capable of making. While some of the presenting symptoms have changed over time, other symptoms (such as amnesia, behavioral fluctuations, and identity alteration) appear un-influenced by the passage of time.

The focus of early and modern case reports is quite different. Early reports are heavily slanted toward neurological and physical explanations. Modern authors, who have the benefit of psychoanalytic theory as well as more sophisticated means of ruling out neurologic causes of alter states, are more psychodynamically focused. The awareness of and attitude toward sexual abuse is markedly different now. Early authors seemed unaware of physical abuse and considered sexual matters unfit for anything but brief mention in Latin, leading to low rates of reported abuse in early cases. It is not possible to say if early patients really had lower rates of abuse since the recognition of trauma as a cause of MPD is simply absent in early reports.

Treatment approaches in early cases were more physical but show a steady progression toward more psychological mindedness in the early twentieth century. The latest of the early reports shows the unfortunate effects of overzealously-applied psychoanalytic theory on interpretation of reports of incest, but also demonstrates the healing power of hypnosis.

Early patients showed remission of symptoms in most cases, despite fairly non-specific treatments. This is likely an artifact of relatively brief follow-up periods and of the inability of early authors to recognize more subtle signs of dissociation. The possibility remains, however, that this was a less abused, less severely ill group whose splits centered around conflicts over emergence into adulthood in a society where social mobility was fairly restricted. The sands of time leave us unable to answer many clinical questions about these patients. Nevertheless, we owe a debt of gratitude to the early authors who gave us a glimpse of MPD in their adolescent patients and who struggled to heal them despite limited knowledge and sometimes crippling social biases.

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REFERENCES

Alexander, V.K. (1956). A case study of multiple personality. *Journal of Abnormal and Social Psychology*, 52, 272-276.

Barrett, W.F. (1887). Automatic writing. *Proceedings of the Society for Psychical Research (London)*, 4, 230-232.

Bowman, E.S., Blix, S., & Coons, P.M. (1985). Multiple personality in adolescence: Relationship to incestual experiences. *Journal of the American Academy of Child Psychiatry*, 24, 109-114.

Burnett, S.G. (1906). A second case of dual personality. *The Medical Herald of the Medical Society of the Missouri Valley*, 25, 485-494.

Carlson, E.T. (1989). Multiple personality and hypnosis: The first one hundred years. *Journal of the History of Behavioral Sciences*, 25, 315-322.

Dean, G.L., Dean, G.S., Burnett, D., & Way, C. (1985). Treatment of MPD in a 16-year-old chemically dependent learning disabled female in an inpatient behavior modification program. In Braun, B.G. (Ed.), *Dissociative Disorders: 1985. Proceedings of the Second International Conference on Multiple Personality/Dissociative States* (p. 100). Chicago: Rush-Presbyterian-St. Luke's Medical Center.

Dell, P.F., & Eisenhower, J.W. (1990). Adolescent multiple personality disorder: A preliminary study of eleven cases. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 359-366.

Dewar, H. (1823). On uterine irritation and its effects on the female constitution. *Transactions of the Royal Society of Edinburgh*, 9, 365-379.

Elliotson, J. (1840). *Human physiology*, (pp. 1165-1166). London: Longman, Orne, Brown, Green, and Longmans.

Fagan, J., & McMahan, P. (1984). Incipient multiple personality in children: Four cases. *Journal of Nervous and Mental Disease*, 172, 26-36.

Fine, C.G. (1988). The work of Antoine Despine: The first scientific report on the diagnosis and treatment of a child with multiple personality disorder. *American Journal of Clinical Hypnosis*, 31, 33-39.

Goddard, H.H. (1926). A case of dual personality. *Journal of Abnormal and Social Psychology*, 21, 170-191.

Gordon, A. (1906). On double ego. *American Journal of Mental Science*, 131, 480-486.

Gruenewald, D. (1971). Hypnotic techniques without hypnosis in the treatment of dual personality. *Journal of Nervous and Mental Disease*, 153, 41-46.

Horton, P., & Miller, D. (1972). The etiology of multiple personality. *Comprehensive Psychiatry*, 13, 151-159.

Kluft, R.P. (1985). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 198-238). Washington, DC: American Psychiatric Press.

Lovitt, R., & Lefkof, G. (1985). Understanding multiple personality with the comprehensive Rorschach system. *Journal of Personality Assessment*, 38, 308-331.

Mayo, T. (1845). Case of double consciousness. *The London Medical Gazette*, 1, 1202-1203.

Wagner, E.E., & Heise, M.R. (1974). A comparison of Rorschach records of three multiple personalities. *Journal of Personality Assessment*, 38, 308-331.

Walters, S.B. (1984). *A delineation and study of the nature of the multiple personality: Toward earlier diagnosis of the multiple personality syndrome*. Ph.D. Thesis, 1981. Ann Arbor, Michigan: University Microfilms International.