

Child Dissociative Checklist (CDC), Version 3

Frank W. Putnam, MD

Date: _____ Age: _____ Sex: M F Identification: _____

Below is a list of behaviors that describe children. For each item that describes your child NOW or WITHIN THE PAST 12 MONTHS, please circle 2 if the item is VERY TRUE of your child. Circle 1 if the item is SOMEWHAT or SOMETIMES TRUE of your child. If the item is NOT TRUE of your child, circle 0.

- 0 1 2 1. Child does not remember or denies traumatic or painful experiences that are known to have occurred.
- 0 1 2 2. Child goes into a daze or trance-like state at times or often appears "spaced-out." Teachers may report that he or she "daydreams" frequently in school.
- 0 1 2 3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive.
- 0 1 2 4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets easily lost.
- 0 1 2 5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.
- 0 1 2 6. Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, athletic abilities, e.g. changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.
- 0 1 2 7. Child shows rapid regressions in age-level behavior, e.g. a twelve-year-old starts to use baby-talk, sucks thumb or draws like a four-year old.
- 0 1 2 8. Child has a difficult time learning from experience, e.g. explanations, normal discipline or punishment do not change his or her behavior.
- 0 1 2 9. Child continues to lie or deny misbehavior even when the evidence is obvious.
- 0 1 2 10. Child refers to himself or herself in the third person (e.g. as she or her)

when talking about self, or at times **insists** on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.

- 0 1 2 11. Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.
- 0 1 2 12. Child is unusually sexually precocious and may attempt age-inappropriate sexual behaviour with other children or adults.
- 0 1 2 13. Child suffers from unexplained injuries or may even deliberately injure self at times.
- 0 1 2 14. Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come from "imaginary companions" or sound like the voices of parents, friends or teachers.
- 0 1 2 15. Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.
- 0 1 2 16. Child has intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes.
- 0 1 2 17. Child sleepwalks frequently.
- 0 1 2 18. Child has unusual nighttime experiences, e.g. may report seeing "ghosts" or that things happen at night that he or she can't account for (e.g. broken toys, unexplained injuries).
- 0 1 2 19. Child frequently talks to him or herself, may use a different voice or argue with self at times.
- 0 1 2 20. Child has two or more distinct and separate personalities that take control over the child's behavior.

The Child Dissociative Checklist (CDC)

Discussion by Ann Aukamp, MSW, BCD

The CDC is a tool which compiles observations by an adult observer regarding a child's behaviors on a 20 item list. Behaviors which occur in the present and for the last 12 months are included. As a research tool, the CDC can quantify dissociative behavior for dimensional approaches and can generate cutoff scores that categorize children into low and high dissociation groups. Research shows that healthy non-maltreated normal children usually score low on the CDC, with younger children scoring slightly higher. As a group, maltreated children score higher than those with no trauma history; however as a group they still score substantially lower than children diagnosed with a dissociative disorder. Generally, scores of 12 or more can be considered tentative indications of sustained pathological dissociation. As with any screening tools, a trained clinician should assess the child in a face to face interview before a diagnosis is confirmed. As a clinical tool, the CDC has multiple uses. It can be a routine screening instrument used in a clinic setting as a standalone tool or in addition to other reporting tools for parents. In special circumstances, teachers or others who know the child reasonably well could be asked to complete it. In these circumstances, allowances need to be made for the observer's familiarity with the child and also the observer's opportunity to observe the child at night. If the observer has no nighttime observation of the child, items 17 and 18 should be ignored. (Putnam, 1997) For finer screening, the CDC also could be administered sequentially in an interval based series. Putnam notes that non-dissociative children often increase their scores by a small amount (1-3 points) over the first few completions because the questions draw attention to minor dissociative behaviors that had not previously been noticed. Last, the CDC can be used as a rough index of treatment progress. While evidence for this use is limited, it seems that the CDC provides a reasonable indication of whether a child is improving over time or with treatment. Putnam reports consistent results on several children from the CDC and clinical observations (Putnam 1997). Users of the CDC are cautioned that CDC scores reported in the literature for the various groups are means that reflect the 'average' child in a given group. Individual children in any of the groups can, and often do, exhibit varying scores on the CDC. Thus, a high score doesn't prove a child has a dissociative disorder, nor does a low score rule it out. Also, since the CDC reports observers' ratings of a child, variations in the observers' interpretations of behavior as well as actual variations in child behavior may affect the variance. This is a potential complication in any observer-based assessment, but it may be especially important when observers are drawn from those whose perceptions may be clouded by their attachment to the child (Putnam, 1997). Bibliography Putnam, F. W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York, NY, Guilford Press.

Date _____ Age _____ Sex: M F _____

1. I get so wrapped up in watching TV, reading, or playing a video game that I don't have any idea what's going on around me..

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

2. I get back tests or homework that I don't remember doing

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

3. I have strong feelings that don't seem like they are mine.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

4. I can do something really well one time and then I can't do it at all another time.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

5. People tell me I do or say things that I don't remember doing or saying.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

6. I feel like I am in a fog or spaced out and things around me seem unreal.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

7. I get confused about whether I have done something or only thought about doing it.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

8. I look at the clock and realize that time has gone by and I can't remember what has happened.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

9. I hear voices in my head that are not mine.

0 1 2 3 4 5 6 7 8 9 10

(never)

(always)

10. When I am somewhere that I don't want to be, I can go away in my mind.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

11. I am so good at lying and acting that I believe it myself.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

12. I catch myself "waking up" in the middle of doing something.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

13. I don't recognize myself in the mirror.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

14. I find myself going somewhere or doing something and I don't know why.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

15. I find myself someplace and I don't remember how I got there.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

16. I have thoughts that don't really seem to belong to me.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

17. I find that I can make physical pain go away.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

18. I can't figure out if things really happened or if I only dreamed or thought about them.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

19. I find myself doing something that I know is wrong, even when I really don't want to do it.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

20. People tell me that I sometimes act so differently that I seem like a different person.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

21. It feels like there are walls inside of my mind.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

22. I find writings, drawings or letters that I must have done but I can't remember doing.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

23. Something inside of me seems to make me do things that I don't want to do.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

24. I find that I can't tell whether I am just remembering something or if it is actually happening to me.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

25. I find myself standing outside of my body, watching myself as if I were another person.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

26. My relationships with my family and friends change suddenly and I don't know why.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

27. I feel like my past is a puzzle and some of the pieces are missing.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

28. I get so wrapped up in my toys or stuffed animals that they seem alive.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

The Adolescent Dissociative Experiences Scale (A-DES)

Discussion by Ann Aukamp, MSW, BCD

The A-DES is a public domain 30-item self report instrument appropriate for those aged ten to twenty-one. It is a screening tool that fits an adolescent's phase-appropriate development. Modeled after the adult Dissociative Experiences Scale (DES), the A-DES was developed by a group organized by Judith Armstrong, PhD, Frank Putnam, MD and Eve Bernstein Carlson, PhD. Preliminary studies suggest that the A-DES is a reliable and valid measure of pathological dissociation in adolescents. Dissociative adolescents (diagnosed independently of the A-DES) scored significantly higher than other adolescent inpatients (Putnam 1997). However, older adolescents with psychotic disorders scored almost as high as dissociative adolescents.

The A-DES is not a diagnostic tool. Its items survey dissociative amnesia, absorption and imaginative involvement (including confusion between reality and fantasy), depersonalization, derealization, passive influence/interference experiences, and identity alteration. The A-DES is scored by summing item scores and dividing by 30 (the number of the items). Overall scores can range from 0-10. Armstrong et. al. gave both the A-DES and the DES to a sample of college subjects and found their scores on each well correlated (Putnam 1997). The A-DES score approximates the DES score divided by 10. Adolescents with Dissociative Identity Disorder typically score between 4-7.

As you consider using the A-DES, please consult the current literature and/or your more experienced colleagues to update yourself about any changes or evolving areas of knowledge. While the A-DES might be used to screen for dissociative experience in large populations in a short period of time or as the basis for a differential diagnosis by a clinician learning about dissociation, its primary use is in the evaluation of dissociative symptoms for individual patients. Clinician's may learn nearly as much from exploring the reasons patients chose to endorse certain items as they would from looking at test scores. Sidran Foundation offers the A-DES along with a short manual about it for a nominal fee. The Sidran Foundation can be reached at (410) 825-8888, or email: sidran@access.digex.net, or on the Internet at <http://www.sidran.org>. You also may download the A-DES from this site.

References

Putnam, F. W. (1997). Dissociation in children and adolescents: A developmental perspective. New York, NY, Guilford Press.

N.B. Both the A-DES and the CDC are available in Putnam's book, above. The versions there are formatted for copy machine duplication and a detailed explanation is

available in the text.

Who are you like? Check the line that describes you best.

A.	Sally likes to eat ice cream a lot.	<u> </u> I'm a lot like Sally.	<u> </u> I'm a little like Sally.	<u> </u> I'm a little like Jackie.	<u> </u> I'm a lot like Jackie.	Jackie doesn't like to eat ice cream at all.
B.	Jenny never wishes she was a grown-up.	<u> </u> I'm a lot like Jenny.	<u> </u> I'm a little like Jenny.	<u> </u> I'm a little like Mary.	<u> </u> I'm a lot like Mary.	Mary often wishes she was a grown-up.
1.	When Sheree gets to school, she sometimes doesn't remember getting there.	<u> </u> I'm a lot like Sheree.	<u> </u> I'm a little like Sheree.	<u> </u> I'm a little like Judy.	<u> </u> I'm a lot like Judy.	Judy, when she gets to school, remembers how she got there and what happened on the way.
2.	Martha, when she wants to, listens to other people and hears most of what they say.	<u> </u> I'm a lot like Martha.	<u> </u> I'm a little like Martha.	<u> </u> I'm a little like Denise.	<u> </u> I'm a lot like Denise.	Denise sometimes realizes in the middle of trying to listen to other people that she did not hear what was just said.
3.	Elaine doesn't get many stomachaches.	<u> </u> I'm a lot like Elaine.	<u> </u> I'm a little like Elaine.	<u> </u> I'm a little like Michele.	<u> </u> I'm a lot like Michele.	Michele gets lots of stomachaches.
4.	Liz often feels like she is standing next to herself watching herself do things.	<u> </u> I'm a lot like Liz.	<u> </u> I'm a little like Liz.	<u> </u> I'm a little like Carrie.	<u> </u> I'm a lot like Carrie.	Carrie has never felt like she was standing next to herself watching herself do something.
5.	Leslie feels guilty (like a bad girl) a lot.	<u> </u> I'm a lot like Leslie.	<u> </u> I'm a little like Leslie.	<u> </u> I'm a little like Nicole.	<u> </u> I'm a lot like Nicole.	Nicole doesn't feel guilty (like a bad girl) very much.
6.	Jan doesn't think about things if she doesn't want to think about them.	<u> </u> I'm a lot like Jan.	<u> </u> I'm a little like Jan.	<u> </u> I'm a little like Joyce.	<u> </u> I'm a lot like Joyce.	Joyce thinks about some things even when she doesn't mean to think about them.
7.	Carmen gets startled easily.	<u> </u> I'm a lot like Carmen.	<u> </u> I'm a little like Carmen.	<u> </u> I'm a little like Gail.	<u> </u> I'm a lot like Gail.	Gail doesn't get startled very easily.
8.	Kathy usually feels like people, things, and everything around her are real.	<u> </u> I'm a lot like Kathy.	<u> </u> I'm a little like Kathy.	<u> </u> I'm a little like Jean.	<u> </u> I'm a lot like Jean.	Jean often feels like people, things, and everything around her are not real.
9.	Danielle often wonders if things she remembers really happened or if she just dreamed them.	<u> </u> I'm a lot like Danielle.	<u> </u> I'm a little like Danielle.	<u> </u> I'm a little like Anne.	<u> </u> I'm a lot like Anne.	Anne usually knows if things she remembers really happened or if she just dreamed them.
10.	Linda talks out loud to herself when she is alone.	<u> </u> I'm a lot like Linda.	<u> </u> I'm a little like Linda.	<u> </u> I'm a little like Julie.	<u> </u> I'm a lot like Julie.	Julie doesn't talk out loud to herself when she is alone.
11.	Rochelle doesn't feel scared very much.	<u> </u> I'm a lot like Rochelle.	<u> </u> I'm a little like Rochelle.	<u> </u> I'm a little like Erica.	<u> </u> I'm a lot like Erica.	Erica feels scared a lot.

Name _____

Date _____

12.	Lisa often feels like she is looking at the world through a fog so that things look far away or fuzzy.	_____ I'm a lot like Lisa.	_____ I'm a little like Lisa.	_____ I'm a little like Cindy.	_____ I'm a lot like Cindy.	Cindy never feels like she is looking at the world through a fog so things look far away or fuzzy.
13.	When Brenda is watching TV, she usually knows what is happening around her.	_____ I'm a lot like Brenda.	_____ I'm a little like Brenda.	_____ I'm a little like Edie.	_____ I'm a lot like Edie.	When Edie watches TV, she sometimes gets so involved that she doesn't know what is happening around her.
14.	Maria doesn't jump when she hears loud noise.	_____ I'm a lot like Maria.	_____ I'm a little like Maria.	_____ I'm a little like Rose.	_____ I'm a lot like Rose.	Rose jumps when she hears loud noise.
15.	Sometimes, Alice has no memory of important things that happened to her (like the first day of school or a birthday party).	_____ I'm a lot like Alice.	_____ I'm a little like Alice.	_____ I'm a little like Ruth.	_____ I'm a lot like Ruth.	Ruth remembers important things that happened to her (like the first day of school or a birthday party).
16.	Renee always recognizes herself when she looks in the mirror.	_____ I'm a lot like Renee.	_____ I'm a little like Renee.	_____ I'm a little like Janice.	_____ I'm a lot like Janice.	Sometimes, when Janice looks in the mirror, she doesn't recognize herself.
17.	Betty feels restless or jumpy a lot.	_____ I'm a lot like Betty.	_____ I'm a little like Betty.	_____ I'm a little like Tammy.	_____ I'm a lot like Tammy.	Tammy doesn't feel restless or jumpy very much.
18.	Sheryl loses her temper a lot.	_____ I'm a lot like Sheryl.	_____ I'm a little like Sheryl.	_____ I'm a little like Robin.	_____ I'm a lot like Robin.	Robin doesn't lose her temper very much.
19.	Tina usually knows if she did something or just thought about doing it.	_____ I'm a lot like Tina.	_____ I'm a little like Tina.	_____ I'm a little like Catherine.	_____ I'm a lot like Catherine.	Catherine often wonders if she did things or just thought about doing them.
20.	Liza always loves to do her homework.	_____ I'm a lot like Liza.	_____ I'm a little like Liza.	_____ I'm a little like Stacy.	_____ I'm a lot like Stacy.	Sometimes, Stacy doesn't feel like doing her homework.
21.	Paula sometimes sits staring off into space, thinking of nothing.	_____ I'm a lot like Paula.	_____ I'm a little like Paula.	_____ I'm a little like Barb.	_____ I'm a lot like Barb.	Barb never sits staring off into space thinking of nothing.
22.	Laura makes up her own games and plays them over and over.	_____ I'm a lot like Laura.	_____ I'm a little like Laura.	_____ I'm a little like Felicia.	_____ I'm a lot like Felicia.	Felicia prefers to play games that most other children play.
23.	When Sheila has a daydream, she knows that the things in her daydream are not really happening.	_____ I'm a lot like Sheila.	_____ I'm a little like Sheila.	_____ I'm a little like Patti.	_____ I'm a lot like Patti.	Patti gets so involved in her daydreams that she sometimes feels like they are really happening.

24.	Angela feels dizzy a lot.	I'm a lot like Angela.	I'm a little like Angela.	I'm a little like Eileen.	I'm a lot like Eileen.	Eileen doesn't feel dizzy very often.
25.	Sandy often feels like she is dreaming when she is awake.	I'm a lot like Sandy.	I'm a little like Sandy.	I'm a little like Teresa.	I'm a lot like Teresa.	Teresa doesn't feel like she's dreaming when she is awake.
26.	Vicky doesn't have very many scary dreams or nightmares.	I'm a lot like Vicky.	I'm a little like Vicky.	I'm a little like Nancy.	I'm a lot like Nancy.	Nancy has lots of scary dreams or nightmares.
27.	Debbie doesn't always feel like she is in her body; sometimes she feels like she is floating away from it.	I'm a lot like Debbie.	I'm a little like Debbie.	I'm a little like Karen.	I'm a lot like Karen.	Karen usually feels like she is in her body.
28.	Once in awhile, Shirley tells a fib.	I'm a lot like Shirley.	I'm a little like Shirley.	I'm a little like Gail.	I'm a lot like Gail.	Gail has never told a fib.
29.	Trina has a lot of feelings (like happy, sad, angry, excited).	I'm a lot like Trina.	I'm a little like Trina.	I'm a little like Sherry.	I'm a lot like Sherry.	Sherry doesn't have any feelings (like happy, sad, angry, excited).
30.	Heidi has trouble falling asleep because pictures or thoughts keep popping into her head.	I'm a lot like Heidi.	I'm a little like Heidi.	I'm a little like Diane.	I'm a lot like Diane.	Diane has no trouble falling asleep when she is tired.
31.	Laurie sometimes feels like her body is doing things she doesn't want it to do.	I'm a lot like Laurie.	I'm a little like Laurie.	I'm a little like Helen.	I'm a lot like Helen.	Helen's body doesn't do things she doesn't want it to do.
32.	Maura has no trouble concentrating on things when she wants to.	I'm a lot like Maura.	I'm a little like Maura.	I'm a little like Yvonne.	I'm a lot like Yvonne.	Yvonne has a hard time concentrating on things even when she wants to.
33.	Beth can remember things easily.	I'm a lot like Beth.	I'm a little like Beth.	I'm a little like Keisha.	I'm a lot like Keisha.	Keisha has a hard time remembering things.
34.	Rachel has a hard time paying attention in class even when she wants to.	I'm a lot like Rachel.	I'm a little like Rachel.	I'm a little like Kim.	I'm a lot like Kim.	Kim has no trouble paying attention in class when she wants to.
35.	Pam rarely feels grouchy for no reason.	I'm a lot like Pam.	I'm a little like Pam.	I'm a little like Carol.	I'm a lot like Carol.	Carol often feels grouchy for no reason.
36.	Dolores feels happy all the time.	I'm a lot like Dolores.	I'm a little like Dolores.	I'm a little like Shelly.	I'm a lot like Shelly.	Sometimes, Shelly feels a little unhappy.
37.	Valerie gets headaches a lot.	I'm a lot like Valerie.	I'm a little like Valerie.	I'm a little like Jane.	I'm a lot like Jane.	Jane doesn't get very many headaches.

Name _____

Date _____

Name _____

Date _____

Who are you like? Check the line that describes you best.

A.	James likes to eat ice cream a lot.	<u> </u> I'm a lot like James.	<u> </u> I'm a little like James.	<u> </u> I'm a little like Ricky.	<u> </u> I'm a lot like Ricky.	Ricky doesn't like to eat ice cream at all.
B.	Brian never wishes he was a grown-up.	<u> </u> I'm a lot like Brian.	<u> </u> I'm a little like Brian.	<u> </u> I'm a little like Marcus.	<u> </u> I'm a lot like Marcus.	Marcus often wishes he was a grown-up.
1.	When Michael gets to school, he sometimes doesn't remember getting there.	<u> </u> I'm a lot like Michael.	<u> </u> I'm a little like Michael.	<u> </u> I'm a little like Kevin.	<u> </u> I'm a lot like Kevin.	Kevin, when he gets to school, remembers how he got there and what happened on the way.
2.	Jason, when he wants to, listens to other people and hears most of what they say.	<u> </u> I'm a lot like Jason.	<u> </u> I'm a little like Jason.	<u> </u> I'm a little like Fred.	<u> </u> I'm a lot like Fred.	Fred sometimes realizes in the middle of trying to listen to other people that he did not hear what was just said.
3.	Adam doesn't get many stomachaches.	<u> </u> I'm a lot like Adam.	<u> </u> I'm a little like Adam.	<u> </u> I'm a little like Brad.	<u> </u> I'm a lot like Brad.	Brad gets lots of stomachaches.
4.	Deonte often feels like he is standing next to himself watching himself do things.	<u> </u> I'm a lot like Deonte.	<u> </u> I'm a little like Deonte.	<u> </u> I'm a little like Scott.	<u> </u> I'm a lot like Scott.	Scott has never felt like he was standing next to himself watching himself do something.
5.	Jack feels guilty (like a bad boy) a lot.	<u> </u> I'm a lot like Jack.	<u> </u> I'm a little like Jack.	<u> </u> I'm a little like Stuart.	<u> </u> I'm a lot like Stuart.	Stuart doesn't feel guilty (like a bad boy) very much.
6.	Philip doesn't think about things if he doesn't want to think about them.	<u> </u> I'm a lot like Philip.	<u> </u> I'm a little like Philip.	<u> </u> I'm a little like Bart.	<u> </u> I'm a lot like Bart.	Bart thinks about some things even when he doesn't mean to think about them.
7.	Ray gets startled easily.	<u> </u> I'm a lot like Ray.	<u> </u> I'm a little like Ray.	<u> </u> I'm a little like Alex.	<u> </u> I'm a lot like Alex.	Alex doesn't get startled very easily.
8.	Joey usually feels like people, things, and everything around him are real.	<u> </u> I'm a lot like Joey.	<u> </u> I'm a little like Joey.	<u> </u> I'm a little like David.	<u> </u> I'm a lot like David.	David often feels like people, things, and everything around him are not real.
9.	Frank often wonders if things he remembers really happened or if he just dreamed them.	<u> </u> I'm a lot like Frank.	<u> </u> I'm a little like Frank.	<u> </u> I'm a little like Vernon.	<u> </u> I'm a lot like Vernon.	Vernon usually knows if things he remembers really happened or if he just dreamed them.
10.	Dan talks out loud to himself when he is alone.	<u> </u> I'm a lot like Dan.	<u> </u> I'm a little like Dan.	<u> </u> I'm a little like Teddy.	<u> </u> I'm a lot like Teddy.	Teddy doesn't talk out loud to himself when he is alone.
11.	Dwayne doesn't feel scared very much.	<u> </u> I'm a lot like Dwayne.	<u> </u> I'm a little like Dwayne.	<u> </u> I'm a little like Nick.	<u> </u> I'm a lot like Nick.	Nick feels scared a lot.

Name _____

Date _____

12.	Andre often feels like he is looking at the world through a fog so that things look far away or fuzzy.	_____ I'm a lot like Andre.	_____ I'm a little like Andre.	_____ I'm a little like Tony.	_____ I'm a lot like Tony.	Tony never feels like he is looking at the world through a fog so things look far away or fuzzy.
13.	When Keith is watching TV, he usually knows what is happening around him.	_____ I'm a lot like Keith.	_____ I'm a little like Keith.	_____ I'm a little like Jerry.	_____ I'm a lot like Jerry.	When Jerry watches TV, he sometimes gets so involved that he doesn't know what is happening around him.
14.	Curtis doesn't jump when he hears loud noise.	_____ I'm a lot like Curtis.	_____ I'm a little like Curtis.	_____ I'm a little like Roger.	_____ I'm a lot like Roger.	Roger jumps when he hears loud noise.
15.	Sometimes, Tom has no memory of important things that happened to him (like the first day of school or a birthday party).	_____ I'm a lot like Tom.	_____ I'm a little like Tom.	_____ I'm a little like Bob.	_____ I'm a lot like Bob.	Bob remembers important things that happened to him (like the first day of school or a birthday party).
16.	Larry always recognizes himself when he looks in the mirror.	_____ I'm a lot like Larry.	_____ I'm a little like Larry.	_____ I'm a little like Leon.	_____ I'm a lot like Leon.	Sometimes, when Leon looks in the mirror, he doesn't recognize himself.
17.	Cliff feels restless or jumpy a lot.	_____ I'm a lot like Cliff.	_____ I'm a little like Cliff.	_____ I'm a little like Alan.	_____ I'm a lot like Alan.	Alan doesn't feel restless or jumpy very much.
18.	Walt loses his temper a lot.	_____ I'm a lot like Walt.	_____ I'm a little like Walt.	_____ I'm a little like Roy.	_____ I'm a lot like Roy.	Roy doesn't lose his temper very much.
19.	Bill usually knows if he did something or just thought about doing it.	_____ I'm a lot like Bill.	_____ I'm a little like Bill.	_____ I'm a little like John.	_____ I'm a lot like John.	John often wonders if he did things or just thought about doing them.
20.	Todd always loves to do his homework.	_____ I'm a lot like Todd.	_____ I'm a little like Todd.	_____ I'm a little like Kent.	_____ I'm a lot like Kent.	Sometimes, Kent doesn't feel like doing his homework.
21.	Paul sometimes sits staring off into space, thinking of nothing.	_____ I'm a lot like Paul.	_____ I'm a little like Paul.	_____ I'm a little like Steven.	_____ I'm a lot like Steven.	Steven never sits staring off into space thinking of nothing.
22.	Barry makes up his own games and plays them over and over.	_____ I'm a lot like Barry.	_____ I'm a little like Barry.	_____ I'm a little like Will.	_____ I'm a lot like Will.	Will prefers to play games that most other children play.
23.	When Wayne has a daydream, he knows that the things in his daydream are not really happening.	_____ I'm a lot like Wayne.	_____ I'm a little like Wayne.	_____ I'm a little like Jay.	_____ I'm a lot like Jay.	Jay gets so involved in his daydreams that he sometimes feels like they are really happening.

24.	Sean feels dizzy a lot.	I'm a lot like Sean.	I'm a little like Sean.	I'm a little like Mark.	I'm a lot like Mark.	Mark doesn't feel dizzy very often.
25.	Ken often feels like he is dreaming when he is awake.	I'm a lot like Ken.	I'm a little like Ken.	I'm a little like Jamal.	I'm a lot like Jamal.	Jamal doesn't feel like he's dreaming when he is awake.
26.	Sam doesn't have very many scary dreams or nightmares.	I'm a lot like Sam.	I'm a little like Sam.	I'm a little like Jeffrey.	I'm a lot like Jeffrey.	Jeffrey has lots of scary dreams or nightmares.
27.	George doesn't always feel like he is in his body; sometimes he feels like he is floating away from it.	I'm a lot like George.	I'm a little like George.	I'm a little like Ron.	I'm a lot like Ron.	Ron usually feels like he is in his body.
28.	Once in awhile, Demetrius tells a fib.	I'm a lot like Demetrius.	I'm a little like Demetrius	I'm a little like Sam.	I'm a lot like Sam.	Sam has never told a fib.
29.	Eric has a lot of feelings (like happy, sad, angry, excited).	I'm a lot like Eric.	I'm a little like Eric.	I'm a little like Bruce.	I'm a lot like Bruce.	Bruce doesn't have any feelings (like happy, sad, angry, excited).
30.	Doug has trouble falling asleep because pictures or thoughts keep popping into his head.	I'm a lot like Doug.	I'm a little like Doug.	I'm a little like Karl.	I'm a lot like Karl.	Karl has no trouble falling asleep when he is tired.
31.	Greg sometimes feels like his body is doing things he doesn't want it to do.	I'm a lot like Greg.	I'm a little like Greg.	I'm a little like Patrick.	I'm a lot like Patrick.	Patrick's body doesn't do things he doesn't want it to do.
32.	Max has no trouble concentrating on things when he wants to.	I'm a lot like Max.	I'm a little like Max.	I'm a little like Charles.	I'm a lot like Charles.	Charles has a hard time concentrating on things even when he wants to.
33.	Ben can remember things easily.	I'm a lot like Ben.	I'm a little like Ben.	I'm a little like Tyrone.	I'm a lot like Tyrone.	Tyrone has a hard time remembering things.
34.	Brett has a hard time paying attention in class even when he wants to.	I'm a lot like Brett.	I'm a little like Brett.	I'm a little like Dennis.	I'm a lot like Dennis.	Dennis has no trouble paying attention in class when he wants to.
35.	Reggie rarely feels grouchy for no reason.	I'm a lot like Reggie.	I'm a little like Reggie.	I'm a little like Matt.	I'm a lot like Matt.	Matt often feels grouchy for no reason.
36.	Malcolm feels happy all the time.	I'm a lot like Malcolm.	I'm a little like Malcolm.	I'm a little like Julius.	I'm a lot like Julius.	Sometimes, Julius feels a little unhappy.
37.	Rick gets headaches a lot.	I'm a lot like Rick.	I'm a little like Rick.	I'm a little like Jim.	I'm a lot like Jim.	Jim doesn't get very many headaches.

Name _____

Date _____

SCORING THE CHILDREN'S DISSOCIATIVE EXPERIENCES SCALE AND POSTTRAUMATIC SYMPTOM INVENTORY
 Bradley C. Stolbach, adapted from Bernstein & Putnam (1986)

A.		Sample Item						
B.		Sample Item						
1.	CDES 1	don't remember getting to school	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		remember getting to school
2.	CDES 2	hear what people say	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		don't hear what people say
3.	CPTSI 1	few stomachaches	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		frequent stomachaches
4.	CDES 3	standing next to self	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		not outside self
5.	CPTSI 2	guilty	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		not guilty
6.	CPTSI 3	few intrusive thoughts	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		frequent intrusive thoughts
7.	CPTSI 4	startle	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		no startle
8.	CDES 4	things are real	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		things aren't real
9.	CDES 5	wonder if dreamed or happened	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		know if dreamed or happened
10.	CDES 6	talks to self	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		doesn't talk to self
11.	CPTSI 5	rarely scared	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		often scared
12.	CDES 7	looking through fog	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		not looking through fog
13.	CDES 8	aware when watching TV	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		unaware when watching TV
14.	CPTSI 6	don't jump at noise	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		jump at noise
15.	CDES 9	trouble remembering events	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		can remember events
16.	CDES 10	recognize self in mirror	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		don't recognize self in mirror
17.	CPTSI 7	often restless or jumpy	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		rarely restless or jumpy
18.	CPTSI 8	often losing temper	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		rarely losing temper
19.	CDES 11	know if did or thought about	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		wonder if did or thought about
20.	Fake 1	love homework	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		sometimes don't like homework
21.	CDES 12	often staring into space	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		rarely staring into space
22.	CPTSI 9	posttraumatic play	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		"normal" play
23.	CDES 13	know daydreams aren't real	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		think daydreams are real
24.	CDES 14	often dizzy	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		rarely dizzy
25.	CDES 15	dreaming when awake	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		no dreaming when awake
26.	CPTSI 10	few nightmares	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		frequent nightmares
27.	CDES 16	not in body	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		in body
28.	Fake 2	fibbing	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		never fibbed
29.	CDES 17	feelings	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>		no feelings
30.	CPTSI 11	bedtime intrusive images	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		easy bedtime
31.	CDES 18	trouble controlling body	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>		can control body

SCORING THE CDES/PTSI, p.2

Bradley C. Stolbach, adapted from Bernstein & Putnam (1986)

32.	CDES 19	can concentrate	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	trouble concentrating
33.	CDES 20	can remember things	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	trouble remembering things
34.	CDES 21	trouble paying attention	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>	can pay attention
35.	CPTSI 12	rarely grouchy	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	often grouchy
36.	Fake 3	always happy	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>	sometimes unhappy
37.	CPTSI 13	frequent headaches	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>	few headaches

For Dissociative Experiences Score, sum items 1,2, 4, 8, 9, 10, 12, 13, 15, 16, 19, 21, 23, 24, 25, 27, 29, 31, 32, 33, 34.

For Posttraumatic Symptom Score, sum items 3, 5, 6, 7, 11, 14, 17, 18, 22, 26, 30, 35, 37.

For Fake Scale, sum items 20, 28, 36.

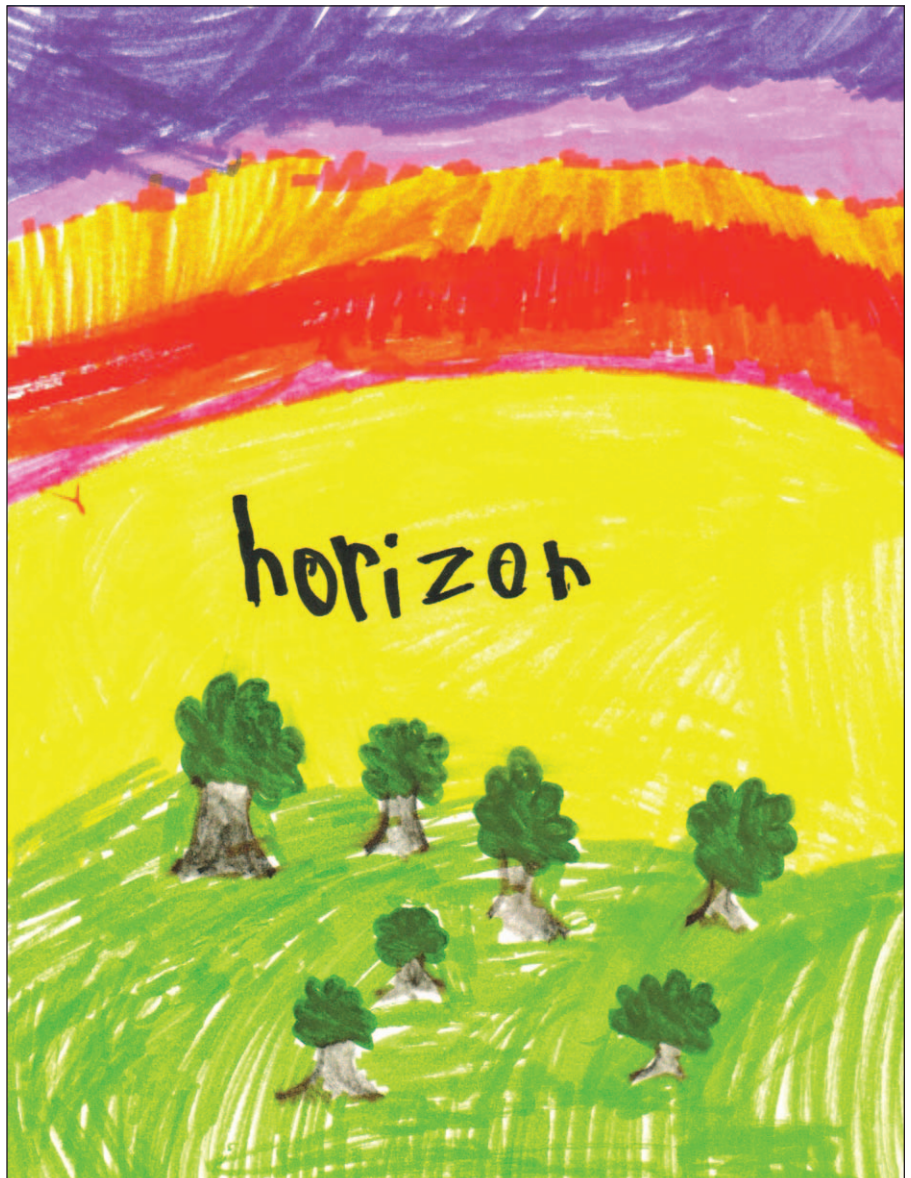
Psychotherapy of a Dissociative 8-Year-Old Boy Burned at Age 3

Despite the clear and established link between dissociative psychopathology and early childhood trauma,¹⁻³ dissociative symptoms often are overlooked in the diagnosis and, more important, treatment of children exposed to potentially traumatic events.^{4,5} A substantial body of evidence supports the idea that dissociation is central to the trauma response and to all trauma-related psychopathology,⁶ and that trauma-related disorders may be best understood as falling on a continuum that begins with peritraumatic dissociation and acute stress disorder (ASD) and ends with dissociative identity disorder (DID) (Figure 1, see page 686).

As summarized by Nijenhuis, van der Hart, and Steele,⁷ the theory of trauma-related structural dissociation of the personality posits that, when a person is traumatized, the traumatic event is not integrated into the memory in the usual way, and aspects of the personality that are associated with the trauma are cut off

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Bradley C. Stolbach, PhD

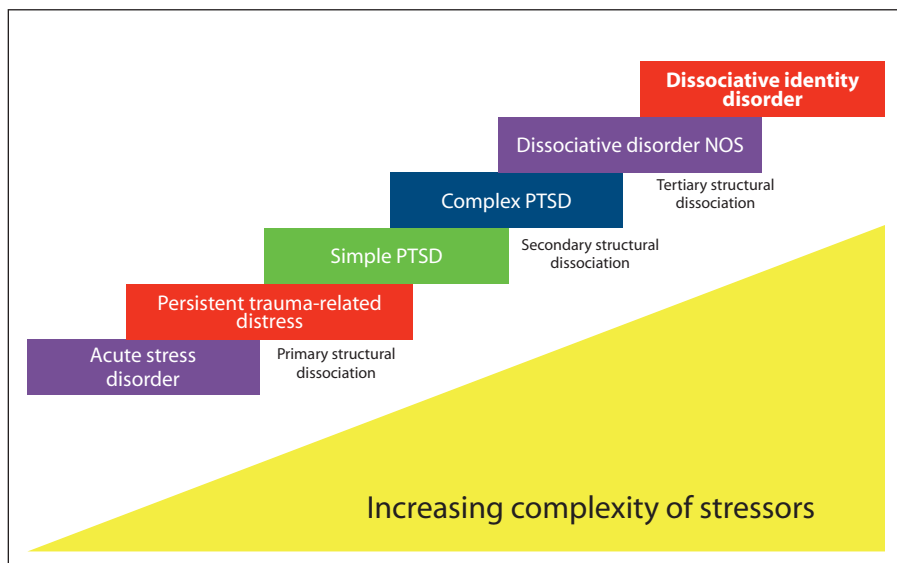


Figure 1. Continuum of pathological outcomes following exposure to potentially traumatic events.

from consciousness. It is then as if the person alternates between two selves: an “apparently normal” personality, which functions as if the trauma never occurred, and an “emotional” personality, which functions as if under continuous threat.⁸

In simple PTSD, these two aspects of the self correspond to the avoidant and intrusive symptoms or phases of the disorder. In more complex trauma-related psychopathology, dissociation leads to dividedness within the emotional part of the personality (eg, complex PTSD; dissociative disorder – not otherwise specified) or within both the emotional and apparently normal parts of the personality (DID).

The study of dissociation, from Janet in the 19th century to Nijenhuis in the 21st, has, not surprisingly, focused on the most extreme and complex end of this continuum, as patients at this end of the spectrum tend to exhibit the most dramatic, bizarre, and perplexing behaviors.⁹⁻¹¹ This is also true of the major published literature on dissociative children.^{12,13} As a result, the role of dissociation in the development, manifestation, and maintenance of less complex trauma-related difficulties often is overlooked. For example, dissociative symptoms are not among the diagnostic

criteria for PTSD in the *Diagnostic and Statistical Manual for Mental Disorders*, fourth edition (*DSM-IV*),¹⁴ despite their inclusion in the criteria for ASD.

Attention to dissociative symptoms is no less important, however, in understanding and treating children at the less complex end of the spectrum of trauma-

related disorders. When clinicians fail to attend to or see dissociative symptoms in these children, we are just as likely to misdiagnose them and our interventions are just as likely to fail as they are at the DID end of the continuum.^{4,5,15}

This article describes a case that involved a single-episode, nonabusive trauma — the accidental scalding of a 3-year-old boy. This trauma led to dissociative psychopathology that interfered with the child’s development and overall functioning in profound ways, and went unrecognized for more than 4½ years,

despite numerous contacts with mental healthcare providers. Attention to dissociative processes and symptoms was crucial to the diagnosis and successful treatment of this child.

PATIENT HISTORY

When Sam was 3 years old, a pot of boiling water spilled on him accidentally, resulting in scald burns to 15% of his total body surface area (TBSA), from his chin, down the left side of his body, to his belly button. Sam was hospitalized for 10 days. His medical recovery was unremarkable and Sam was not disfigured; when clothed, only one small scar under his chin was visible after his burns healed.

As is often the case for burn patients, Sam did not receive any psychological or psychiatric services as part of his burn care.¹⁶ Sam was referred to me 4½ years after the burn took place, by the social worker in the burn center where he had been hospitalized. Sam’s mother, Ms. C, had contacted the social worker due to her desperation and frustration over

The study of dissociation, from Janet in the 19th century to Nijenhuis in the 21st, has, not surprisingly, focused on the most extreme and complex end of this continuum, as patients at this end of the spectrum tend to exhibit the most dramatic, bizarre, and perplexing behaviors.

the ineffectiveness of interventions for Sam’s numerous emotional and behavioral problems.

When she first contacted me, Ms. C reported that Sam (now 7 years, 10 months) had experienced a 33% TBSA burn and had been hospitalized for a month at age 3. It was only when she brought in Sam’s medical records that we realized she had more than doubled the quantifiable variables in describing Sam’s experience. I understood this distortion as her attempt to communicate how horrible this experience had been,

Self-Reported Dissociative Symptoms

- CDES total 30 (of possible 63; clinical range = 24 or greater)
- Not hearing what was said
- Wondering if things happened or were dreamed
- Wondering if he did things or just thought about doing them
- Looking at the world through a fog
- Body does things he doesn't want it to do
- Trouble concentrating
- Trouble remembering things
- Trouble remembering events
- Talks to self

Mother-Reported Dissociative Symptoms

- CDC total 17 (of possible 40; clinical range = 12 or greater)
- Daze or trance-like state
- Rapid personality changes
- Forgetful
- Variation in skills, knowledge, etc.
- Rapidly changing physical complaints
- Unusual nighttime experiences, sleep walking

CDES = Children's Dissociative Experiences Scale; CDC = Child Dissociative Checklist.

as well as her response to the repeated dismissals of her concerns when she tried to convince people that Sam's difficulties were largely related to his experience of being burned. Ms. C explained that she had sought out a variety of services for Sam in the years since the burn and that nothing seemed to help. She reported that, before the burn, Sam had been a happy, very smart boy, who was developing normally, was toilet trained, and was beginning to learn to read. After he was burned, Sam's personality changed completely; he lost previously acquired developmental skills, became timid, and stopped eating.

Ms. C reported that, in the time since the burn, Sam had been diagnosed with separation anxiety disorder, irritable bowel syndrome, and "receptive language deficits." At the time he presented, he was receiving occupational therapy for "sensory integration dysfunction,"

and he could not read. In addition, Sam weighed only 47 pounds, and several professionals had expressed concerns about a possible eating disorder. Sam had participated in a year-long psychotherapy at age 5 that was focused on his parents' separation and divorce.

Ms. C reported that none of the services Sam had received had addressed his experience of being burned and that none

many of Sam's difficulties were related to it. After talking with Ms. C, I told her that it was possible that some of Sam's problems were indeed related to his experience of being burned, and I agreed to see Sam for trauma-focused assessment.

When I first met Sam and his mother, I began by explaining to Sam that I had worked with many children who had experienced burns, and that being burned didn't just hurt people's bodies, but also hurt them inside, "in their feelings." I explained that, just like his body had healed after he was burned, the "inside" hurts also needed to heal, and it was my job to help with this. I suggested to Sam and his mother that, once this healing took place, internal resources and energy now devoted to the trauma would become available for the tasks of everyday life.

I told Sam and his mother that my purpose in conducting a trauma-focused assessment was to try to understand how the experience of being burned had affected him, how he was coping with its effects at present, and whether the kind of treatment I could provide might be helpful to him. Sam told me that his burn did not bother him because he couldn't remember it and that nobody, including me, could help him learn to read.

INITIAL ASSESSMENT

At this first assessment session, Sam exhibited extreme separation anxiety, appearing visibly terrified at the thought of his mother leaving the room. He had a

Ms. C reported that none of the services Sam had ever received had addressed his experience of being burned, and that none of the professionals who worked with Sam had ever even discussed the burn with her or Sam, despite her belief that many of Sam's difficulties were related to it.

of the professionals who worked with Sam had ever even discussed the burn with her or Sam, despite her belief that

difficult time keeping still during the session and got up and walked around during much of the initial clinical interview.

Despite his anxiety and activity level, Sam was able to complete several self-report measures during this session while his mother completed several parent-report measures. Based on his own report, Sam clearly met the diagnostic criteria for PTSD, although he did not report experiencing symptoms that are usually hallmarks of the disorder: intrusive recollections or trauma-related nightmares. He endorsed only one reexperiencing symptom — intense psychological distress at reminders of the traumatic event — and four avoidance symptoms. Based on Sam's report and those of his mother and teacher, he was experiencing all of the physiological arousal symptoms that comprise PTSD Criterion D. Sam also endorsed numerous symptoms of attention-deficit/hyperactivity disorder, all of which were likely due to his high levels of arousal and dissociation. He clearly met the diagnostic criteria for a separation anxiety disorder. He did not report clinical levels of symptoms of any other disorder.

Ms. C's responses to the Child Behavior Checklist (CBCL)¹⁷ were consistent with Sam's reports and clinical presentation, placing him in the normal range on the "delinquent" and "aggressive" behavior scales and at the 99th percentile for internalizing, "thought problems," and "attention problems." One of the most striking parts of the assessment was the consistency of Sam's report and Ms. C's report regarding dissociative symptoms (Sidebar, see page 688). It is unusual for parents to be able to report pathological dissociation in their children accurately, as these symptoms are highly subjective and internal and are not easily observed by others. Both Sam and his mother endorsed numerous dissociative symptoms, placing him well into the clinical range on both the Children's Dissociative Experiences Scale (CDES)¹⁸ and the Child Dissociative Checklist (CDC).¹⁹

While he did not meet the diagnostic criteria for a *DSM-IV* dissociative disorder,



Figure 2. Sam's artwork illustrates his feeling of "bouncing off the walls" and not listening, behavior indicative of his regression to age 3, the age at which his injuries occurred.

der, dissociative symptoms were clearly central to Sam's problems. Because Sam's PTSD was not obvious, particularly to people who were not aware of his burn history, and because his symptoms were primarily of an internalizing nature, people tended to minimize or overlook his level of distress and to attribute his social and academic struggles to situational factors, family factors, or a lack of effort. At the completion of the assessment, I diagnosed Sam with PTSD with related dissociative symptoms and a separation anxiety disorder and recommended burn-related trauma-focused psychotherapy. After hearing my feedback and recommendations, Sam told me that he didn't think about getting burned so it didn't bother him. Due to scheduling conflicts, there was a 3-week hiatus before treatment could begin.

THERAPEUTIC PROCESS

When Sam and his mother returned for the first therapy session, two things became clear immediately. The first was that Sam's dissociation of his burn ex-

perience had been highly adaptive; the second was that I had underestimated the level of his dissociative psychopathology and the degree to which his personality and daily functioning had been shaped by it. Sam and Ms. C both reported that, since our last meeting, he had been "bouncing off the walls" (Figure 2). Additionally, he had had several incidents of enuresis and encopresis, and Ms. C reported that Sam was "not listening," that she had to repeat things many times and literally "get in his face" to get his attention. In the 3 weeks since I had seen him, Sam's behavior had changed from that of an anxious, "spaced out" 7-year-old (his apparently normal self) to that of a typical 3-year-old (his emotional self).

I interpreted the changes in Sam's functioning as a direct response to the assessment that we had just completed. Although the assessment did not require Sam to talk about the details of the burn, it had forced him to think and talk about things that he had not thought or talked about for 4½ years. During those years,



Figure 3. Sam drew this picture of a bear from a recurrent nightmare he experienced.

Sam's development and personality had been structured around cutting off trauma-related memories, thoughts, and feelings and keeping them inaccessible to consciousness and to his day-to-day "apparently normal" self. By bringing the traumatic event back into consciousness, we had opened up the floodgates for all of Sam's trauma-related feelings and behaviors, and they had come rushing back.

I interpreted and normalized what had happened during the 3 weeks and

explained to Sam that, when all of the trauma-related material was activated, his body and mind responded as if the trauma were occurring now. I told him, "Your body doesn't know that you're almost 8 years old. Sometimes it thinks you're 3." We talked about the fact that his brain could tell his body, "That's crazy," "I'm big," "I'm not 3, I'm almost 8 years old," and that the burn is in the past and he is safe now.

I also had Sam make a list of the people, places, and things that help him to feel safe and big, and had Sam pair these associations with a nightlight. Whenever his body started to act like he was 3, Sam was to press the nightlight and it would help him to remember that he was big and safe. At the end of this and subsequent sessions, Sam was prompted to say, "I'm safe. It's over. It's in the past."

The day after this session, Ms. C called me, distraught. She reported that Sam had woken up in the middle of the night screaming and terrified and that it had taken a long time to soothe him. After he calmed down, Sam told her, "The bear is back." After he was burned, Sam had a recurring nightmare involving a malevolent bear chasing after him; he had not had one of these dreams in over 2 years. I reassured Ms. C that it was not unusual for children to experience an

increase in symptoms after beginning trauma-focused psychotherapy and that young children often have nightmares about monsters as opposed to replications of the trauma. After seeing Sam's drawing of the moment when the scalding water spilled on him and a drawing of the bear that he had done at age 5 (Figure 3), I concluded that Sam had transformed the burning water into the bear and that the bear nightmares were, in fact, literal reenactments of the traumatic event.

Sam's psychotherapy has had two major components occurring simultaneously: the integration of Sam's memories of the trauma (often described as "exposure"), and the integration of dissociated aspects of Sam's personality (often referred to as "parts work"). With children traumatized at a very early age, it is important to work with the child and primary caregiver together, if the caregiver has the capacity to do this.²⁰ There are aspects of the traumatic event the child does not know and the caregiver does (often contextual details or things that happened when the child was not conscious), as well as aspects of the trauma that the caregiver does not know and the child does (often the child's subjective experience and perceptions or events during which the caregiver was not present). By working with the caregiver and child together, it is often possible to put all of these pieces together.

Throughout Sam's treatment, work on the story of the burn has involved both Sam and Ms. C telling the story of the burn with words and drawings. When they began telling the story, Sam (who, before this, had consistently denied remembering what happened) reported that his then 7-year-old sister, who was angry, had pushed him into his cousin who was holding the pot of water (Figure 4). This was information Ms. C had never heard before. During the first phase of telling the story, Sam experienced an increase in bear nightmares



Figure 4. Sam's depiction of the scalding accident that led to his dissociative symptoms: "Mandy pushed Sam into Alice and then the pot fell on him because Alice had it in her hands. The water went on Sam from the top of his scalp down the left side of his face, down the left side of his body, his neck, his shoulder, his chest, down past his belly button, and leaning toward his right side slightly past the belly button. Sam screamed."



Figure 5. Based on the psychotherapist's metaphor, Sam drew this image of himself running while carrying a boulder, a situation that puts him at a disadvantage compared with the other runners in the race. He inserted the cheering spectators on his own.

and separation anxiety. By modifying the nightlight intervention to stabilize Sam's sleep, we were able to reduce his nightmares and anxiety.

As we continued to focus on integrating the details of his burn experience, he experienced a reduction in his "spaci-

ness," sleep disturbance, and difficulty concentrating. However, as Sam's dissociative and hyperarousal symptoms decreased, new behaviors emerged. He began to express anger at home and was reported to be "angry and disrespectful" at school. Not surprisingly, Sam's teach-



Figure 6. Mom was going to put Sam in the car seat, but something told her not to. She thought if she let Sam go, he would die. She drove to the hospital with Sam next to her on the front seat, lying partially on her. She held him with her right arm and drove with her left. She said Sam was completely quiet; in fact, after the first scream, he didn't make a sound. He held onto her. There were towels wrapped around him, but she didn't think there was any blood; Sam thought there was. Mom was crying hysterically all the way to the hospital. Sam was rubbing her arm and twirling her hair.

ers had never observed such behavior before, as Sam had effectively dissociated the "angry part" of himself and previously had little conscious access to his anger.

In session, Sam expressed his anger and frustration over not being able to read. He resented the other children his age who were able to read without a struggle. We talked about how many children who have been hurt think that they are weak, or damaged, or not as good as other kids. I told Sam that, in fact, other children had had it a lot easier than he because they didn't have to deal with being burned when they were 3. I introduced the metaphor of a race in which only one of the runners must carry a boulder: the other runners will get to the finish line first, but that does not mean the runner with the boulder is slow. In fact, the strongest runner is the one who must carry the boulder. He will get to the finish line later than the other runners, but his achievement will be much more impressive.

While we discussed this metaphor, Sam drew it (Figure 5), inserting cheering spectators on his own. This intervention, focusing on strength that Sam had previously viewed as weakness, acknowledged that his anger was appropriate and acceptable and made it possible for Sam to enter the next phase of his treatment — focusing on the most painful and previously least accessible aspects of his burn experience.

Telling the story of what happened after the water spilled on Sam involved talking about some of the most frightening moments of both his and his mother's lives. It also meant including things that happened after both Sam and Ms. C had entered into intense dissociative states (Figure 6).

Ms. C reported that she felt sick while telling this part of the story. Sam reported that he did not feel anything and that he remembered his mother putting him in the front seat but didn't remember anything else. After telling the story,

Sam said, "I'm safe, it's over, it's in the past," without any prompting.

He then said he was hungry and asked his mother for a sandwich. When Ms. C responded that she had forgotten to bring sandwiches, Sam went into a regressed state, put his head down on the table, began sobbing, and did not respond to questions. I helped Sam to get up and go over to his mother, and I had him physically reenact the drive to the hospital by lying across his mother the way he had in the car. I instructed Ms. C to put her arm around him in the position they had been in during the drive, and say, "I'm sorry you got burned." Sam responded by saying, "I don't care about that." I instructed Ms. C to apologize for forgetting the sandwiches. We then focused on the fact that Sam loves his mother and his mother loves him even when he feels mad or disappointed.

At the following week's session, Sam had had only one bear nightmare, and Ms. C reported that he was more present and involved at school. On several occasions, he had told her to turn off the news when he overheard a disturbing story. She reported that "before he wouldn't even have noticed" that the news was on, let alone taken in its content.

Sam was reluctant to draw about the next part of the story, so Ms. C drew it and Sam was instructed to color it (Figure 7). It was clear from this part of the story that Sam had taken care of his mother at the time of the burn by reassuring her, and that he continued to take care of her by trying to cut off those aspects of his experience and himself that were unbearable to her. This included any expression of sadness, fear, or anger.

Following this phase of treatment, many of Sam's symptoms improved. He was attending and enjoying day camp and sleeping in his own bed some of the time. His separation anxiety had improved significantly, enabling him to attend a 1-week sleep away camp for burn survivors and, following his return, to go swimming



Figure 7. Mom ran through the triage area and ran back to where the doctors were. A woman asked Mom if she could help her. Mom just ran by and she was screaming: "Somebody please help me," and "I need a doctor," and "There's not much time." Alice was crying. Sam cupped Mom's face in his hands and said, "Mama, don't cry. I be OK." Lots of nurses and doctors converged on Sam and started cutting his clothes off him. They started putting some cream on Sam's burns. Mom felt like they were putting the cream on her.

by himself for the first time.

After his return from burn camp, Sam expressed a great deal of anger, mostly directed at his older sister. In the subsequent weeks, he had frequent nightmares, although he no longer dreamt of the bear. Although he had difficulty an-

swering questions about his nightmares, Sam had no trouble drawing what he dreamt (Figure 8). Sam's dreams were now about the different aspects of his personality that he had worked so hard to cut off but that had become accessible to his consciousness as he integrated his



Figure 8. A depiction of another of Sam's nightmares: "There is thunder, fire, and a wolf. Thunder is scary. If you go up, the wolf attacks you. If you go down, you get burned."

burn experience: the divided parts of his “emotional personality,” associated with feeling anger, fear, and pain or vulnerability, and the “apparently normal personality” that tried unsuccessfully to escape from these parts.

In previous sessions, we had talked about the part represented by the wolf as the “mad or angry” part of Sam. I now reframed this as the part of Sam that could fight. We talked about the moment when the scalding water landed on Sam and he screamed. I explained that his immediate biological reaction to the pain before he shut down, which was to feel anger, was a natural, involuntary survival response and that humans respond to physical pain with anger because it prepares them to fight. We talked about the fact that he had shut down this part of himself when he was burned because it is impossible to fight scalding water and that the “fighting” part of him did not have to be scary or bad but rather was the part that had given him the strength to survive being burned, and even to try to take care of his mother in the midst of it. The fire in the dream represented the part of Sam that could be hurt, which he subsequently labeled as “gross and scary.” We talked about how feeling pain, while not fun, is part of being human and being alive, and that the part of him with the capacity to feel pain also gives him the capacity to feel love and joy.

The least complicated part of Sam’s treatment involved the integration of his traumatic experience, which led relatively quickly (within 10 sessions) to the resolution of his PTSD and separation anxiety disorder. The more complex and difficult part of his treatment, which is not yet complete, is focused on Sam accepting and integrating all the different parts of himself: the fighting part, the

“scary and gross” part that feels, the 3-year-old Sam trying to have the fun he missed for 4½ years, and the 8-year-old Sam trying not to feel anything. Several weeks into this phase of his treatment, Sam came in and announced that he could read. As the dissociated aspects of both his traumatic experience and his personality become integrated, less energy is spent on keeping them out of awareness and divided, leading to healing and the availability of internal resources to manage present demands.

In one of his first therapy sessions Sam drew a picture that he labeled “Horizon” (see page 685). The horizon is the dividing line between the aspects of the world, the earth and sky. It is also the place where they are brought together, a point of integration and harmony. I have come to think of this drawing as a representation of Sam’s destination, a place where the previously divided aspects of his experience and personality come together to form something vibrant and beautiful.

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Assessing and Diagnosing Dissociation in Children: Beginning the Recovery

Frances S. Waters

The first reported case of childhood dissociation by Antoine Despine in 1836 was of a 12-year-old girl, Estelle (Ellenberger, 1970). However, it wasn't until a century later that a slow resurgence of writings about childhood dissociation occurred (Bowman, Bix, & Coons, 1985; Braun, 1985; Riley & Mead, 1988; Chu & Dill, 1990; Coons, 1985; Fagan & McMahon, 1984; Kluft, 1984, 1985; Weiss, Sutton, & Utecht, 1985). Since then, there is a steadily growing literature on the topic including historical perspectives (Silberg, 2000; Silberg & Dallam, 2009) research studies (Becker-Blease et al., 2004, 2011; Kisiel & Lyons 2001; Macfie, Ciccehetti, & Toth, 2001; Shimizu & Sakamoto, 1986), comorbidity studies (Kaplowa, Hallb, Koenenc, Dodged, & Amaya-Jacksone, 2008; Malinosky-Rummel & Hoier, 1991), case studies (Coons, 1996; Dell & Eisenhower, 1990; Stolbach, 2005; Waters, 2011), theoretical (Putnam, 1997) and clinical books (Shirar, 1996; Silberg, 1996/1998; Wieland, 2011), dissociative checklists (Armstrong, Putnam, Carls, Libero, & Smith, 1997; Dell, 2006; Evers-Szostak & Sanders, 1992; Putnam, Helmers, & Trickett, 1993; Steinburg, 1994; Stolbach, 1997), and conferences around the globe. To add to our deeper understanding of the nosology of dissociation, the recent publication by Dell and O'Neil (2009) provides a comprehensive sourcebook.

The International Society for the Study of Trauma and Dissociation (ISSTD; www.isst-d.com) sponsored initially the journal, *Dissociation* (which can be downloaded for free at the University of Oregon Library, <https://scholarsbank.uoregon.edu/xmlui/handle/1794/1129>). In 2000, ISSTD launched its own journal, the *Journal of Trauma and Dissociation*, to continue bringing scholarly works to professionals. ISSTD's website has expanded to include guidelines for evaluation and treatment of childhood dissociation and FAQs (frequently asked questions) for parents and teachers. ISSTD's professional training institute offers comprehensive courses on childhood dissociation that are taught internationally and online. ISSTD also sponsored the training DVD, *Trauma and Dissociation in Children* (Waters, 2007), to assist professionals, particularly forensic evaluators and prosecutors, in understanding dissociative signs and effective strategies in child abuse and neglect investigations.

While the bulk of the literature has continued predominately to focus on adult dissociation, these efforts shed light on how to accurately assess dissociation in children and are slowly gaining momentum in educating professionals, academics, parents, and teachers about the convoluted presentations of dissociative youth. However, because dissociative children have a high rate of comorbidity and a continuation of misinformation about dissociation, these children continue to be misdiagnosed for more popular or widely known diagnoses, such as attention deficit hyperactivity disorder (ADHD), bipolar, psychoses, conduct disorder, etc. (McElroy, 1992; Waters, 2005a).

THEORETICAL DEVELOPMENTS AND CONCEPTUALIZATION OF DISSOCIATION

Since the early 1990s, many theoretical models from different disciplines have emerged to provide a broader perspective of our understanding of the disruption of memory, consciousness, and identity. Contributions in the field of neurobiology (Bremner et al., 2003; Bremner; 2005; Stein, Koverola, Hanna, Torchia, & McClarty, 1997; Vermetten, Schmahl, Lindner, Loewenstein, & Bremner, 2006) examine how trauma affects certain brain structures and impairs consciousness and memory. The attachment and relational theories (Liotti, 1992, 2009; Lyons-Ruth & Jacobvitz, 1999; Main & Solomon, 1986; Siegel, 1999) focus on the child's traumatic relationship with the parent and the development of dissociative processes and disorders.

In the dissociative field, a number of theories have emerged. I will briefly cite some of them. Putnam (1997) views dissociation as a defense mechanism to overwhelming fear of annihilation resulting in compartmentalization of painful affect and memories and an estrangement from self.

Putnam further examines in his *Discrete Behavioral States Model* (1997) the early development of an infant's discrete shifts in response to the mother's erratic and abusive care. These discrete shifts form templates for segmenting frightening and confusing experiences from the self-beginning stages of dissociation.

van der Hart, Nijenhuis, and Steele (2006) detailed their model, *Structural Dissociation of the Personality*, based on early works of Pierre Janet, in which the traumatized self separates according to two complex action systems. One system, the apparently normal personality (ANP) enables an individual to perform necessary functions, such as work. The emotional personality (EP) is action system fixated at the time of the trauma to defend from threats. The EP contains traumatic memories and associated traumatic affect, thoughts, and behaviors. These action systems can further fragment into tertiary systems containing many ANPs and EPs that take on additional actions for the self.

Stein and Kendall (2004) present the *Global Psychological Effects of Chronic Traumatic Stress on Children Model*, based on the early works of Lenore Terr's Type 2 trauma (1991) that examines the impact of chronic trauma on the child's developing brain, alterations in consciousness and memory, disturbance in identity, difficulty in regulating emotions and level of arousal, hyperactivity and attention, relationship problems, and alterations in belief system.

The Proposed Developmental Trauma Disorder (van der Kolk, et. al, 2009) for consideration in the DSM-V focuses on the impact of multiple exposures to interpersonal trauma that causes dysregulation of somatic, affective, self and relational, and posttraumatic spectrum symptoms. This disorder lasts more than 6 months and causes significant functional impairment, including dissociation.

Waters' (1996, 2011) *Quadri-Therapeutic Model for Treating Dissociative Children* is a comprehensive model that combines the use of four theories in assessing and treating dissociative children: Attachment (Bowlby, 1973, 1980; Mahler, Pine, & Bergman, 1975; Main & Solomon, 1986), developmental (Erikson, 1968; Piaget, 1954), family systems (Bowen, 1978; Minuchin, 1974; Satir, 1983), and dissociative theory (Putnam, 1997).

The attachment theory of this model is derived from Bowlby's framework of a child's psychological responses to the loss of a parent. He describes grief and mourning stages that the child experiences as behavior directed to the lost object, hostility, appeals for help, despair, withdrawal, regression, disorganization, and reorganization of behavior directed toward a new object. My model, based on Bowlby's model of how a child copes with separation from a parent, is comparatively a *window* on how a child must survive the devastating psychological impact when exposed to frightening, confusing, or abusive parents. In my comparison model, the child, being in a devastating, helpless, untenable situation, finds a way out through dissociating affect, sensations, loss of idealized parent, etc. The child's response is to internalize the unbearable, intense affect of underlying fear, grief, mourning, and vulnerability and the associated coping behaviors into self-states, such as internalized abusive parent state, helper/friendly state, angry state, depressed state, sexualized state, etc. The states can be fragmented, less developed, or more developed as seen in dissociative identity disorder (DID).

The development theory of this model includes Erickson's Theory of Psychosocial Development (1968) that examines the formation of ego identity, a conscious sense of the self shaped by daily social interactions. The development of the self is constantly changing by new experiences. He details eight stages of relational experiences beginning at birth that, if successfully reached, build competency, capacity for intimacy, and a secure sense of self into old age. However, my model recognizes that traumatic experiences during childhood disrupt the development of identity, trust, autonomy, intimacy, etc., resulting in some degree of identity confusion and fragmentation.

Mahler's theory (Mahler et al., 1975) of separation and individuation also provides a conceptualization of developmental phases beginning at infancy to achieve a healthy identity. Mastery of each phase will help to develop a sense of individual identity. However, early child maltreatment, particularly by the mother, disrupts the child's developmental process to achieve healthy individuation. Safe exploration of emotions and the environment is then precluded. Consequently, the child may rely on dissociation and fragmentation of the self as a way to defend against feeling overwhelmed by the original trauma and subsequent traumatic triggers in the environment. This will therefore impair the child's ability to attain individuation with unified self-identity.

The family system theory in the quadri-theoretical model is based on works of Bowen (1978), Satir (1983), and Minuchin, (1974) which view the family as an emotional unit and examines the interplay among family members. Destructive interactions within the family, such as maltreatment or disruption in attachment, can cause or influence dissociative defenses. Family systems approach examines family members and their own history of trauma, unresolved attachment, dissociation, mental illness, etc. My model emphasizes the importance of engaging the entire family in assessment and treatment to improve effective communication and relationships, eliminate any behaviors that influence dissociation, and provide a safe environment.

The quadri-theoretical model provides a comprehensive and integrative perspective by examining how multiple theories intersect to provide a foundation for understanding the development and complexities of dissociative defenses in children. This conceptualization is helpful in assessment and throughout the treatment process.

All of these theoretical models—neurological, attachment, relational, dissociative—are derived from various disciplines and converge with overlapping constructs to greatly enhance the credibility and understanding of the etiology of dissociation. *These models all acknowledge the underlying cause of dissociation resulting from childhood trauma, abuse, and neglect.*

Regardless of contemporary studies, theoretical models, and training opportunities, childhood dissociation is often overlooked, misunderstood, or disbelieved today. Kluft (1984, 1985) attributes this phenomenon to the lack of recognition of dissociative behaviors in children that are expressed differently from dissociative adults, who exhibit more discrete presentations. Also, there is a disbelief or skepticism of children's reports of voices accounting for their misbehavior or children's denial of their behavior. Because caretakers will punish them for "lying" or reporting separateness, dissociative children are further inhibited to disclose such influences.

van der Hart, Nijenhuis, and Steele (2005) also postulate another crucial reason for overlooking dissociation in traumatized individuals. Professionals miss how trauma can involve some degree of division or dissociation within the self and that evaluators view dissociation as peripheral, not a central feature of PTSD.

More popular or widely recognized disorders, such as ADHD, adjustment disorders, somatization disorder, developmental disorder, and bipolar disorder, are assigned to traumatized children but dissociation is unrecognized, (McElroy, 1992; Waters, 2005a) resulting in cumulative years of emotional pain, identity confusion, memory problems, unresolved trauma, and ineffectual treatment.

ASSESSMENT PROCESS FOR CHILD AND ADOLESCENT DISSOCIATION

Conducting a thorough assessment of children with complex trauma does not occur in a single session or a series of early sessions but is an ongoing process.

As with the Adaptive Information Processing Model (AIP) in eye movement desensitization and reprocessing (EMDR) (Shapiro, 2001), each phase brings reassessment of the client's ability to move forward to effectively process trauma. Clinicians are continually gaining more information through all phases and reassessing how to intervene. Dissociative symptoms may not appear until the later stages of EMDR treatment, particularly during trauma processing. It would be advisable to assess the degree of dissociation before proceeding.

Exploring all forms of trauma, including physical, sexual, emotional, witnessing domestic violence, medical/illnesses, exposure to war or natural disasters and accidents, their chronicity, and familial responses are integral to assessing how the child defended against such experiences and whether dissociative processes were employed. Understanding these processes will assist the EMDR clinician to prepare for effectively processing the memories of trauma and adversity with children using EMDR treatment and the AIP model.

Dissociation can be nonpathological or pathological. Some signs of nonpathological dissociation are daydreaming or zoning out, fantasy, or absorption while playing a video game. These experiences do not involve any self-fragmentation and generally do not hinder the overall adjustment of the child unless there is some compulsive quality, such as hours of computer game playing that interrupts sleep or homework.

Pathological dissociation can range from moderate to severe. Moderate forms are derealization and depersonalization. Moving along the continuum of severity is the formation of self-states. These self-states may only operate internally, without taking

executive control over the body, but nevertheless, they can greatly influence the child's mood, sensations, behavior, and memory. These children are diagnosed with dissociative disorders not otherwise specified (DDNOS). The most severe form of dissociation is the presence of discrete self-states that take executive control over the body, resulting in considerable memory problems, identity confusion, and more pronounced mood and behavioral switches. These children would meet the diagnosis of DID. Below is a more thorough description of these indicators.

CORE DISSOCIATIVE INDICATORS AND CASE DESCRIPTION

Peterson (1991) provides a child dissociative problem checklist, and Hornstein and Putnam (1992) examine clinical phenomenology of child and adolescent dissociative disorders. When evaluating for core dissociative indicators, utilizing valid dissociative checklists with a thorough interviewing process is warranted. The core dissociative indicators presented are often interrelated, influenced, and/or dependent on the other indicators. Dissociative symptoms can suddenly appear and disappear quickly or only appear occasionally depending on what activates them. It is because of the fluidity of such symptoms that they are often overlooked or misunderstood.

In describing each of the core dissociative indicators, I will describe a case example of a 9-year-old adopted Asian girl, Lisa, that I treated. Lisa lived with her adoptive parents and two brothers. Her mother provided extensive history of worsening, severe emotional and behavioral problems with Lisa since adoption. Lisa was only able to handle school for a half day since the beginning of her academic career and would often be sent home for frequent explosive behaviors at school and severe peer problems. At 9 years old, Lisa was still unable to open a bottle or hold silverware.

Her mother noted when Lisa came to the United States at 4 months old, she slept the entire trip regardless of being overly dressed and drenched. She was unresponsive to the heat and displayed signs of sensory processing difficulties even at this young age. The parents were not given any trauma history when Lisa was placed with them, but they noted that she had a swollen gum that appeared to be a tumor. An examination by a pediatric dentist indicated that it was not a tumor but was due to some unknown trauma to the gum. From infancy through preschool, Lisa was extremely orally defensive and feeding was a traumatic experience for her as well as her parents, as she would refuse a bottle or spoon until she was starving. She would violently swing her little arms and kick furiously if anyone came close to her. She fought having her teeth brushed. She was clearly behaving as if she was traumatized orally. Her tongue held out of her mouth, and she drooled until she was 5 years old, as she did not develop facial muscles until then. She did not recognize herself in the mirror until her mother taught her to do so at age 3. She would often have a blank look on her face.

Lisa did not bond with her adoptive mother. When Lisa would decompensate, she would display a disorganized attachment pattern of screaming and thrashing if her mother came close to comfort her. Then when her mother would walk away, Lisa would chase after her mother in fear and agony, protesting her mother's withdrawal. Lisa was utterly inconsolable, highly disruptive, and raged for hours and her mother was equally desperate for solutions. Lisa frequently would not remember these outbursts and would have a glazed look in her eyes when questioned. These sudden mood and behavior switches were often unprovoked or unpredictable. This was a common pattern repeated throughout her young life. Lisa was inconsolable and highly disruptive for hours.

Lisa's early and increasingly disturbing behavior prompted her mother to frantically search for answers by seeking various assessments. At 18 months of age, Lisa was evaluated by an occupational and speech therapists. She was diagnosed with low motor development and "splintered" physical abilities. She had significant speech and language delays. She received occupational and speech therapy since then to the time of my evaluation.

Her mother consulted with the adoption agency for advice on how to handle Lisa during her preschool years. She was advised that Lisa had reactive attachment disorder and was directed to do holding therapy (Welch, 1988), a technique of forced, prolonged holding of a child by a parent or therapist to develop attachment with the parent. This technique has met with controversy. The mother was directed to not stop holding Lisa until she began to bond with her. Lisa fought vigorously, passed out, and woke up only to resume struggling to get away from her mother, who had held her for hours. Being held down activated her stress response system, increasing her fear and consequently her dissociation. Lisa's rages increased.

A psychiatrist evaluated Lisa at 6 years of age. He reportedly was unsure of Lisa's diagnosis but gave her the diagnoses of an anxiety disorder and oppositional defiant disorder (ODD). He prescribed an antidepressant and later added an antipsychotic medication, but her mother discontinued them due to no improvement.

Desperate, Lisa's mother sought help from a well-known and respected child guidance center that diagnosed Lisa with a developmental disorder not otherwise specified and ODD. Ruling out an affective disorder was considered. Lisa was noted to have behavioral, sensory, emotional, cognitive, and academic problems. The recommendation was behavioral therapy, which proved to be ineffective. Lisa's family had severely limited their activities due to Lisa's explosive behavior.

Lisa's mother then sought an assessment from me at the same time that she brought Lisa to a chiropractor, who provided stunning independent diagnostic impressions that were complimentary to mine, which I will explain as I highlight Lisa's core dissociative symptoms under the headings below.

Amnesia

Children can have fluctuations in their memory, including not recalling past or present traumatic and/or nontraumatic experiences. Their memory can be spotty or episodic. At one time they may remember events and at another time they may not have knowledge of those events, or they may only have a sketchy memory of the events. They may recall parts of their trauma and describe accompanied sensory distortion, such as tunnel vision or only hearing bits of the event. They may not recall their teachers, schoolwork, holidays, or even their parents, as in the case with Lisa.

In my first interview with Lisa, while she was playing with the dollhouse, I inquired about any memory problems. She simply and clearly stated, "It takes me a while to remember who my parents are." She also said it took a while to remember her brothers, as well. With further questioning, she reported not recognizing her homework when returned to her or tests she had taken, and activities she had done with her family. She also indicated that she would be accused of hitting her siblings but have no memory of such behavior.

Inconsistent memory for disruptive behavior with dissociative children can be misconstrued by parents and professionals that the children are lying or manipulating to avoid consequences. While it is exasperating for adults to manage these episodes,

it is often more confusing, frustrating, and frightening for dissociative children to be accused of something for which they have no memory doing. While children may manipulate to avoid repercussions, traumatized children often have significant memory problems and dissociation should be carefully explored as a viable possibility. An empathic approach will decrease children's shame and encourage them to explore dissociative barriers and what underlying factors contribute to their amnesia.

Children's episodic memory can be dependent on many factors, such as, whether they have sufficient ego strength to handle the memory, particularly if it is traumatic, the safety of the environment, and the awareness of a trance state that contains the information of current or past events. In addition, simply asking children in an empathic manner about such experiences will often provide them the opportunity to discuss their amnesic experiences, as with Lisa, who seemed relieved to tell me about them.

Trance Behavior and Trance States or Self-States

Along the continuum of moderate to severe range of dissociation, children may stare off or "zone out" when they want to escape due to anxiety or traumatic reminders. With chronically abused children, trance behavior can become habitual even with mild stressors, which are often noted by teachers. During those times, the children may have difficulty reporting what transpired just before they zoned out or what motivated such behavior. Sometimes, because of embarrassment they will say that they were bored in school. It is important to further explore whether these periods have more significance and a pattern related to a certain affect, traumatic triggers, and/or the presence of a self-state.

A more severe form of dissociation is the presence of self-states. Young children who have auditory or visual hallucinations of people may identify them as "imaginary friends" and not distinguish them as self-states until they are older and able to assimilate their meaning. These "imaginary friends," however, may express intense affect and conflicts with each other (Frost, Silberg, & McIntee, 1996) and cause considerable distress to the child. I have treated a number of small children who have emphatically insisted that their "imaginary friends" or "angry voice" are real and not pretend.

Children can create self-states of various ages with different roles, affect, and behaviors that may directly relate to their traumatic experiences (Waters & Silberg, 1998). They may be given names that describe their function and have special significance to the child, such as hero figure, perpetrator, or mad part. They can have various degrees of influence over the child's mood, behavior, sensations, thoughts, and relationships.

Some self-states who identify with the perpetrator engage in aggressive or self-harming behaviors, such as cutting one's self, assaulting others, etc., usually attract the most attention from parents and professionals. They are often the focus of interventions and diagnosed with ODD or conduct disorder. There may also be self-states who assume identification with hero figures and who "rescued" the child when abused by "helping her fly away" or by taking the abuse for her.

Sometimes self-states are simply "reporters" of traumatic memories *without any affect*. This presentation can confuse professionals who may doubt that the trauma was really experienced, or they may minimize the traumatic impact on the child. But as Steele explained in the training DVD, *Trauma and Dissociation in Children* (Waters, 2007), "... this is a hallmark of dissociation. It didn't happen to me, or it happened to me and

it doesn't really matter. There's no affect to it. There's no feeling tone to it. There's no sense of personal ownership." (This is also a sign of depersonalization, which is highlighted below.)

Because chronically traumatized, dissociative children are easily sensitized to even minor stimuli, they can rapidly switch self-states when triggered. These trance states can appear and disappear suddenly without apparent provocation and may contain only specific memories related to their own experiences. Their awareness of other self-states or their current environment may be precarious depending on protective barriers between each other. They can emerge after being hidden for years by taking executive control over the child's body or harass the child from within with degrading comments, or pressure the child to engage in self-destructive or aggressive acts. Self-states can appear, engage in aggressive behavior, and then disappear, leaving the child bewildered. These children are often accused of lying when they deny such behavior.

Lisa described a total of five self-states over several months. During the time period when she was evaluated by the chiropractor, Lisa revealed to me two baby self-states, Mary and Tommy. The chiropractor, unaware of Lisa's dissociative states, made a remarkable assessment that she had retained her primitive infant reflexes. Lisa was diagnosed with asymmetrical tonic neck reflex (ATNR) that infants display until 6 months old and then normally vanish. The signs are when eyes move in one direction, the neck moves in the same direction; when head moves in one direction, the arms and legs move in that direction, etc. Lisa's infantile reflexes were attributed to the presences of these baby states! Furthermore, they continued to influence and limit her physical adroitness and strength, as she was unable to open a bottle and effectively hold silverware.

Lisa also identified Helper, the internalized mother. Another adult helper, Shadow, was revealed after Lisa reported seeing internally a shadowy figure. Cindy, a 9-year-old angry self-state, became known during one of the explosions. Lisa appeared to switch rapidly from a helpless baby state that had extreme separation anxiety to Cindy, who would rage if her mother came close to comfort her when she was wailing. Baby's Helper and Shadow were often in direct conflict with Lisa's mothering aiming to take control. Switching from one state to another was accompanied with significant amnesia resulting in a chaotic life of fear and confusion that not only severely impaired her memory, behavior, and affect, but it also adversely affected her ability to attach to her mother.

When children have extreme and contradictory presentations, particularly severe developmental delays (regressed behavior), the existence of trance states of different ages should be considered and carefully assessed. While self-states initially helped the child survive the trauma, later some can wreak havoc on the child's life until their presence are known and their traumatic role has been processed. Resistance to interventions, denial of behaviors, and erratic presentations are critical warning signs for the clinician to explore the presences of self-states.

Extreme Mood and Behavior Switches

Rapid and extreme fluctuations in mood and behavior can often be seen as a form of bipolar disorder or ODD, particularly if they are taken at face value and not understood as a part of the etiology of dissociation. Dissociative children's mercurial presentation of sudden shifts is unpredictable, confusing, and challenging to manage. As noted above, these fluctuations are often attributed to rapid switching of self-states that have divergent affect, such as happy, mad, sad, scared, etc. They can demonstrate changeable

preferences to food, dress, toys, activities, and contain contradictory thinking patterns and sudden somatic complaints, such as headaches, stomachaches, and painful extremities. While it appears confusing to the caregiver or professional, these extreme mood and behavior switches should be explored to see if they are a result of fragmentation and creation of self-states. A detailed mapping of these shifts by the parents can provide the EMDR assessor a valuable composite picture of triggers and shifts in presentation for accurate diagnosis.

Lisa demonstrated rapid switching when she felt physically threatened, was in crowds, witnessed someone at school being hurt, took long trips (her long journey to this country when adopted), and when father traveled on business (fear of abandonment, as she was closest to him). These were all traumatic reminders instigating dissociative defenses. Parts of her would either take executive control or she would internally feel their intense affect. Her moods swung from fear to aggression to despondency, in which she would wail for hours wanting to die. Her skill levels were erratic and particularly dependant on her baby states, in which she would regress to baby talk and infantile mannerisms or physical capabilities.

Auditory and Visual Hallucinations

The presence of voices and images of floating objects, faces, figures, or shadows are frequently characteristic of children with DDNOS or DID. These hallucinations originate from traumatic experiences and are indicators of fragmentation. As previously reiterated, the voices can be antagonistic, friendly, helpful, or destructive.

Teens may be hesitant to report voices for fear of being seen as “crazy.” Asking children in an empathic way about their hallucinations, while explaining that other children with similar trauma histories have reported these types of experiences, can minimize their resistance to reveal them. I will often explain that the voices are part of them that helped them in some way with “the bad things that happened to them, even the voice that seems angry.” This approach has helped children to begin to understand the meaning of the voices and reduce their anxiety and phobia toward that state. It will also increase the angry state’s willingness to cooperate in therapy.

So that I may be able to understand the child’s perception of the visual hallucinations of the “scary figures,” etc., I will ask the child to draw a picture of them during the initial phases of EMDR treatment in order to assess dissociative responses more thoroughly. Their drawings will diagnostically provide much data about the child’s perception of their voices or self-states, such as how well their identity is developed, how powerful they are, and how scary the child perceives them. Some children may draw a head or a complete body that is large with oversized arms and scary-looking faces.

In the preparation phase of EMDR treatment, I will provide further psychoeducation about these parts containing feelings that the child was unable to handle alone and how the parts also need help to learn to express themselves in appropriate ways. Helping to demystify these hallucinations can help to engage the children to express their inner experiences.

Lisa was very open to reporting about her auditory and visual hallucinations. It was a relief to her to be able to understand them and to begin to have some control over their influence. Her mother was often present during these sessions and was very nonjudgmental, empathetic, and supportive, which greatly helped Lisa to overcome some shame about them, particularly associated with embarrassing behavior.

Once children understand that their frightening voices or images were originally formed to help them survive, their fear and resistance to disclose them is lessened.

Depersonalization and Derealization

While depersonalization and derealization were mentioned above, it is worth highlighting here in depth.

Steele, Dorahy, van der Hart, and Nijenhuis (2009) eloquently describe depersonalization as: (1) the existence of an observing and experiencing ego or part of the personality (Fromm, 1965); (2) detachment of consciousness from the self or body (i.e., feelings of strangeness or unfamiliarity with self, out-of-body experiences); (3) detachment from affect, such as numbness; (4) a sense of unreality, such as being in a dream; and (5) perceptual alterations or hallucinations regarding the body (Noyes & Kletti, 1977). Derealization involves a sense of unreality or unfamiliarity with one's environment, and distortions of space and time (Steinberg, 1995, p. 162).

Steele et al. (2009) believe that many forms of depersonalization and derealization are alterations of consciousness and memory.

Shimizu and Sakamoto's (1986) research describes 16 cases of depersonalization that developed before the age of 15. The majority of dissociative children that I treated who described depersonalization and derealization experiences also had self-states present at that time. However, I worked with an adoptive teenager who did not disclose any self-state related to his feelings of depersonalization and derealization.

Regarding Lisa, she had considerable depersonalization predominately related to her mouth, but also to other parts of her body that would become activated when she ate. For example, Lisa did not feel her mouth, did not taste or smell her food, and was unaware of how she was chewing her food. She was desensitized to food that drips on her arms, lap, and legs. Upon further exploration, while Lisa's baby states did not take executive control over her body, they were internally influencing her sensory losses. This example demonstrates the complexity of tweaking what is affecting the prolonged symptoms of children who may appear to parents to be careless, sloppy, and resistant to correction, but truly are numb to their bodily senses.

ASSESSMENT TOOLS

Along with a thorough interview process, there are some gold standard dissociative assessment tools for children and adolescents that are valid and reliable. These tools can further aid the EMDR evaluator in diagnosing as part of a complete assessment.

A common caregiver checklist is the *Child Dissociative Checklists* (CDC, Putnam et al. 1993) that has been used also by teachers to rate children's behavior. It is geared for children from preschool to 12 years old.

The most widely used standardized measurement for caregivers and teachers is the *Child Behavior Checklists* (CBCL, Achenbach, 1992). The CBCL evaluates children's internalizing and externalizing behaviors and is often used for diagnosing ADHD. However, this checklist has the following items that overlap with dissociative symptoms: acts too young for age, can't concentrate, can't pay attention for long, confused or seems to be in a fog, daydreams or gets lost in his/her thoughts, stares blankly, sudden changes in mood or feeling. Studies (Malinosky-Rummel & Hoier, 1991; Sim et al., 2005) have included the CBCL in effectively detecting dissociation in children.

There are a number of dissociative self-report checklists. A commonly used one is the 30-item questionnaire, *Adolescent Dissociative Experience Scale* (ADES) (Armstrong et al., 1997). The more comprehensive 218 questionnaire, *Adolescent Multi-Dimensional Inventory of Dissociation v.6.0* (Dell, 2006), rates 14 major facets of dissociation. It can be obtained by contacting Dr. Dell at pfdell@aol.com.

Stolbach's (1997) *Children's Dissociative Experiences Scale & Posttraumatic Symptom Inventory* (CDES-PSI) is a self-report for children designed for 7- to 12-year-olds, but the author has communicated that he has found it helpful with adolescents, as well (Stolbach, personal communication, May 2006). This checklist is valid for differentiating traumatized children from nontraumatized children and is easy for children to fill out. While there are no valid norms for dissociation, I have found this helpful in detecting dissociative symptoms with traumatized children. For those younger children who do not read, I have read the questions in a matter-of-fact way so as to not skew the results.

The *Children's Perceptual Alteration Scale* (CPAS, Evers-Szostak & Sanders, 1992) is a self-report measure of dissociation for children 8 to 12 years old. It was derived from the Perceptual Alteration Scale for adults (Sanders, 1986) and is a helpful measurement for childhood dissociation as well as normal development and childhood psychopathology.

Briere's (1996) self-report, *Trauma Symptom Checklist for Children* (TSCC), has six clinical scales: Anxiety, depression, posttraumatic stress, dissociation, anger, and sexual concerns. There are three dissociative questions that can be used to signal a need for a more thorough evaluation with one of the specific dissociative checklists. Even if a child doesn't endorse dissociation on the TSCC, I also administered one of the dissociative checklists, particularly when the child displays dissociative symptoms.

Steinburg developed the *Structural Clinical Interview for DSM Dissociative Disorders* (SCID-D) (1994), which requires training, and can be used with adolescents who can maintain sustained attention and have an average or higher level of cognitive functioning.

When caregivers and children significantly endorse items on the checklists, I will follow-up with a request for clarification.

DIFFERENTIAL DIAGNOSES AND COMORBIDITY

Shapiro's (2001) Adaptive Information Processing Model explains that when an individual is under high arousal as a result of trauma, the information processing is thwarted. Consequently, the traumatic experience is maladaptively stored, resulting in symptoms. Traumatized children and adolescents often have a high level of comorbidity as a result of unprocessed trauma. These symptoms can confuse or mask their traumatic origin and the sequelae of dissociation. It is the myriad of symptoms that are seen with traumatized children, such as extreme mood swings, inattention, and oppositional behavior that are given more commonly known or accepted diagnoses, such as bipolar disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder (ADHD). Even when recent reports of traumatic experiences were provided, unfortunately, clinicians will disregard their significance and diagnose according to the most florid or disturbing symptom, thus ignoring any dissociative phenomenon (Waters, 2005a). This is particularly serious, as early detection and proper processing of the trauma, including the use of EMDR, can save children from years of escalating symptoms that have been resistant to previous treatments and medication regimens.

Overarching complexity of co-morbid symptoms in dissociative children is that these symptoms can be brief and intense, or lasting for days, months, or years, and then

suddenly disappear. Because these erratic symptoms are often contained in self-states of children with DID or DDNOS, as highlighted previously, it is often confusing to the diagnostician to see the correlation between sudden, sporadic symptoms contained in brief presence of self-states. Self-states can have specific behavioral or emotional problems that stem from how they were affected by the trauma. *Consequently, there can be an exhaustive list of co-morbid symptoms and diagnoses ascribed to dissociative children.*

Frequent co-morbid symptoms or diagnoses commonly seen in dissociative children are PTSD, ADHD, ODD, bipolar disorders, psychotic disorders, substance abuse, obsessive-compulsive disorder, sexual problems, conduct disorder, somatoform disorders, anxiety, depression, and eating disorders.

Lisa's mother was an excellent reporter of Lisa's symptoms and kept copious notes describing her daughter's convoluted presentation in detail. Nevertheless, Lisa was diagnosed with an anxiety disorder and ODD by the psychiatrist and later by a child guidance clinic. Neither considered her early history of infant trauma and dissociative symptoms.

To assist the EMDR evaluator, I will address three common misdiagnoses ascribed to dissociative children that have overlapping or similar presentations but contain distinctive differences that are ignored.

Attention Deficit Hyperactive Disorder

There are many overlapping symptoms with ADHD and dissociation that often mask the dissociation. Clinicians who are unfamiliar with dissociative signs of trance states will ascribe traumatized children's inattention or daydreaming to ADHD. Research by Malinosky-Rummel and Hoier (1991) cite these similarities with traumatized children who scored in the significant range on dissociative checklists as well as on the CBCL's dissociative symptoms. As noted before under *Assessment Tools*, common signs on the CBCL for dissociation that are particularly seen with children with ADHD are inattention, feeling in a fog, staring, and daydreaming. It is crucial for proper treatment that trauma and dissociation be evaluated before assuming that it is ADHD-Inattention type.

Bipolar Disorder

Bipolar disorder is a dysregulation of the affective system in which there are swings in mood from hypomania to depression, usually lasting weeks or months. In the last decade, there has been a dramatic change in a more permissive, less rigorous standard in diagnosing children with bipolar disorder, and 90% of those diagnosed are receiving medication with little testing for effectiveness or safety (Moreno et al., 2007). The rate of diagnosis of pediatric bipolar disorder has increased 40 times in the last 10 years (National Institute Mental Health [NIMH], 2007). Diagnoses of bipolar disorder in children and youth increased 4,000% from 1994–1995 to 2002–2003. This has resulted in considerable controversy over this diagnosis.

One of the hallmarks of dissociation is the rapid, extreme mood and behavioral switches that can last from seconds to hours, and are sometimes accompanied by amnesia. As explained above, these extreme switches can be attributed to self-states with intense affect, but all too often dissociation is not diagnostically considered.

A seminal article by Parry and Levin (2011) critically examines multidimensional factors that influence the overdiagnosis and misdiagnosis of pediatric bipolar disorder,

including the impact of popular books, the media, and pharmaceutical industry, and the lack of examining developmental trauma and attachment factors on affect dysregulation.

Janet Papolos, co-author of *"The Bipolar Child: the Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder"* (Papolos & Papolos, 2000), in an interview on National Public Radio's Infinite Mind (Lichtenstein, 2005) related parents describing their children as,

Dr. Jekyll and Mr. Hyde ... the child has the LOOK [in capital letters per her report]. Their eyes get very glazed and the child gets a feral look like he is fighting for his life ... after it is over, the child doesn't remember it. They often sleep and don't even remember it and if they do remember, they feel so badly.

This is a classic verbatim of dozens of parents' descriptions of their dissociative preschool and older children that I (Waters, 2005b) and others (Silberg, 1998; Wieland, 2011) have described.

There is a paucity of bipolar studies that note a history of childhood physical and sexual abuse (Blader & Carlson, 2006; Hyun, Friedman, & Dunner, 2000; Levitan et al., 1998; Mueser et al., 1998; Wexler, Lyons, Lyons, & Mazure, 1997). There is a need for more professional education on discerning the difference between overlapping symptoms of bipolar disorder and the relationship between trauma and dissociation in children and adults. There have been presentations addressing this issue at conferences (Levy, 2009; Waters, Laddis, Soderstrom, & Yehuda, 2007).

There is one refreshing article in which Harris (2005) describes a case example of a 10-year-old boy previously treated for bipolar disorder with escalating series of medications. Upon a careful case analysis, the boy described severe beatings by his grandparents and clearly described dissociative symptoms of depersonalization and derealization when triggered. He reported, "I just see red ... I don't really know where I am or what I'm doing ... I don't really feel in my body." (Harris, 2005, p. 530). More research is required to understand the correlation between traumas, affect dysregulation, and dissociation.

The child guidance center that evaluated Lisa had considered Lisa having an affective disorder, but seemed confused as to what attributed to her affect dysregulation. Dissociation was not discussed.

Hallucinations, Psychosis, or Schizophrenia

Moskowitz (2011) offers a valuable historical description of two opposing paradigms when examining hallucinations and how auditory and visual hallucinations have been predominately viewed as psychotic with primarily a biological origin (brain disorder) rather than being influenced by psychological factors, such as traumatic experiences. This staunch, enduring position of hallucinations being psychotic has greatly influenced the DSM and overshadowed the pioneering work of Bleuler's (1911/1950), who described schizophrenia as "split off" of the personality.

Because of this "split" in the paradigms and the strong focus that hallucinations are a brain disorder, the recognition of overlapping dissociative symptoms of auditory and visual hallucinations has greatly contributed to misdiagnosing dissociative patients with a psychosis or schizophrenia (Bliss, Larson, & Nakashima, 1983; Rosenbaum, 1980; Ross, Joshi, & Currie, 1990; Ross, Norton & Wozney, 1989).

A major distinction between psychosis and schizophrenia and DDNOS or DID is that dissociative clients' reports of auditory or visual hallucinations are attributed to *self-states* that formed as a *result of traumatic related experiences* (Kluft, 1987a; Ross, Joshi, & Currie, 1990). Furthermore, Sar and Ozturk (2009) explain,

The dissociative patient's reported claim of containing another person's existence, or of having more than one personality, cannot be considered a delusion. Such claims do not originate from a primary thought disorder, but rather from experience itself—the actual experience of the other as “not me” (Sullivan, 1953). In contrast, the delusions of a schizophrenic patient are thought to be the result of a primary disturbance of thought content. (pp. 536–537)

I have encountered in my practice many traumatized children and adolescents who reported auditory and visual hallucinations derived from self-states but were given a previous diagnosis of a psychotic disorder. Their treatment modality was a psychopharmacological approach without any efficacy and attention to the meaning of the voices and their traumatic origin.

Numerous studies and clinical vignettes have described hallucination in dissociative children and adolescents with DDNOS and DID (Coons, 1996; Dell & Eisenhower, 1990; Hornstein & Putnam, 1992; Putnam, 1997; Silberg, 1996/1998; Shirar, 1996; Waters, 2005b, c; Wieland, 2011).

It is crucial for dissociative children's recovery that EMDR diagnosticians become familiar with trauma-related hallucinations within self-states so that these symptoms are not misdiagnosed as psychotic or schizophrenic and prescribe a treatment regime that is antithetical to effective, integrative therapy of a fragmented traumatized youth. For a more comprehensive analysis of differential diagnosis of hallucinations, I encourage the reader to see *Part X: Dissociation and Psychosis* by Dell and O'Neil (2009, pp. 519–568).

COMPONENTS IN THE INTERVIEWING PROCESS

As in other assessments, many factors determine how to proceed with interviewing the child and family members. Relevant factors to consider are professional standards, clinical judgment and style, purpose of the interview, child's age, and how comfortable the child is to being seen alone or with the parent. I usually see the child or adolescent initially with the parent or caregiver, unless the teen wants to be seen alone, to gather basic referral and identifiable information and some developmental history. I note particularly how the parent(s) and child interact with each other and define the problem. At some point, I will talk to the parent alone to gather more detailed developmental and trauma histories and symptoms. I will interview the child alone to assess his overall functioning, his relationship with his family members and peers, trauma and academic history, and symptoms. As deemed necessary, I will request to interview other family members.

When Lisa's mother requested that I evaluate her daughter, she was desperate and fraught with concern. Her brief description of her daughter's history on the phone was clear to me that I needed to gather a detailed history from her mother prior to seeing Lisa so that I could intervene quickly and effectively with Lisa. I met with her mother for 2 hours and gathered a chronologically well-organized description of Lisa's symptoms from her placement with them at 4 months old to present including a developmental, academic, social, and family history, and I reviewed previous evaluations and interventions. My hypothesis was that the origin of her symptoms was oral trauma of

unknown cause that occurred sometime during her Asian foster home placement, and that she was exhibiting dissociative defenses.

Lisa's had severe emotional dysregulation. Included in phase one of EMDR treatment is an evaluation of emotional regulation capabilities. Adler-Tapia and Settle (2008) stress the importance of developing affect regulation skills particularly with dissociative children so that they can stay connected to the therapy. That was also my goal as Lisa identified self-states that accounted for her labile mood.

Assessing the Family Environment

The impact of the family environment on the development of childhood dissociation cannot be understated, nor can the reliance on previously formed dissociative mechanisms. It is well accepted that in order for children to be treated, they need a safe environment. As Silberg points out, "I believe increasingly hostile and lonely environments that make real connections and relationships impossible further encourage the consolidation of dissociative symptoms" (Silberg, 2001, p. 1). Others have described negative environmental influences on shaping dissociative defenses in children, particularly with parents who also display dissociation (Benjamin & Benjamin, 1992; Benjamin, Benjamin, & Rind, 1996; Mann & Sanders 1994; Peterson & Boat, 1997; Yeager & Lewis, 1996). These children are particularly vulnerable to reoccurring abuse. However, Kluff (1987b) discusses the parental fitness of mothers with DID.

I have treated dissociative parents on both ends of the spectrum, from providing a safe environment to abusing their children, necessitating a child protection referral. The dissociative adults who seemed to provide a stable environment for their children were those who actively sought treatment and processed their pain. In turn, they were able to be sensitive, empathetic, and protective parents.

A thorough parental history that includes any trauma, attachments to their own parents, dissociation, and legal, financial, medical, and other mental health conditions will help the evaluator to determine their relevance to the dissociative child's symptomatology.

I have worked with dedicated foster and adoptive parents who also had significant trauma, unresolved attachment issues, and dissociation who became triggered by their demanding, dissociative children. Some abused their children. Referring parents to therapy, support groups, and respite care can prevent maltreatment or reinstate a safe environment.

Fortunately for Lisa, her parents came from a stable environment with healthy attachments to their parents who provided support. Both parents appeared to have a healthy, traditional marriage in which the mother stayed at home while the father was gainfully employed. There were no significant problems noted. Mother did have a high-risk pregnancy after Lisa was adopted, necessitating that she maintain bed rest for the latter part of her pregnancy. This mostly exacerbated Lisa's symptoms. Their other two children were healthy and well adjusted. They tolerated Lisa's acting out, but it did put stress on them.

History Gathering From the Parent Regarding Their Child

It is important to ask questions about trauma and dissociation, even when the presenting problem is nontrauma related. Parents often seek services for the most disturbing symptom, such as oppositional behavior, attention problems, and anger issues, and may be unaware of the underlying causes. If parents do report some form of trauma that their child incurred, they may not understand the relevance to their child's symptoms.

Gathering from the parents a thorough developmental history from pre-birth to the child's current age will assist in assessing any causal relationships to the presenting symptoms. Questions should include all forms of interpersonal trauma, separation from parents, painful medical conditions and interventions, accidents, war exposure, natural disasters, as well as relationship with parents, siblings and peers, academic performance, extracurricular activities, and any court/legal involvement. Building a time line of significant events correlated to the child's age and onset of symptoms will assist in developing a causal relationship.

Particular attention in history gathering of trauma should include whether the child's parents were available to assist the child to cope. Any signs of dissociative symptoms should be explored. Since parents often do not know what dissociative signs are, educating them about indicators will elicit a more accurate and complete response. The issues to be covered are signs, frequency, and duration of any trance behaviors; persistent denial of disruptive or explosive behavior even after disciplined; extreme mood and behavior switches activated by minor stimuli or for "no apparent reason"; and other memory problems beyond ordinary forgetfulness of significant and/or daily events, particularly after an explosive incident. It is easy to perceive the child's denial of such behavior as avoiding responsibility, but memory problems are common with dissociative children. Requesting details of an incident will help to track gaps in the child's memory.

The following is a list of questions that will assist in identifying dissociative symptoms. Depending on the parent's response, some questions may not be necessary. This is a guide for the clinician to use with discretion. Many of these questions correlate with ISSTD's Frequently Asked Questions for Parents (www.isst-d.org). (While questions apply to both males and females, for simplicity, male gender is used below.)

List of Questions to Ask Parents

- Do you see your child staring, unresponsive, or in his own world (not including when playing video games or watching television)? How often and how long?
- Does your child have extreme mood and behavior switches, and if so, describe those times and what you notice about his behavior and affect? Does he seem different at those times, and if so, in what ways?
- Does your child have a favorite food, activity, clothing, etc., but then hates it another time?
- Do you notice any changes in the child's eyes, such as blinking, fluttering, eye roll and/or change in voice, mannerisms during these times?
- Does your child deny his aggressive/disruptive behavior even when you witnessed it? How does he respond to you at those times? Does he continue to deny such behavior even after he was disciplined? Does he deny other behaviors or situations that are not problematic, i.e. conversations or activities?
- Has your child ever said he hears voices or sees things/people, but no one was around? Describe those times.
- Have you heard your child talk to himself and/or refers to himself in the third person? Does he sound like he is using a different voice during those times? Does he seem younger or older?
- Does your child have an imaginary playmate (beyond 8 years old)? Describe what you notice.
- Does your child look and behave differently at times that are not attributed to illness? Describe those times in detail.

- Does your child have memory problems to events that he should recall, such as holidays, birthdays, etc., past and present?
- Does your child adamantly deny you told him to do his homework, or chores when you were facing him, engaging with him in the conversation, and he wasn't engaged in any other activity, such as computer, TV, etc.?

These questions, which were described earlier, were asked of Lisa's mom, which laid the foundation for my interview with Lisa.

Interviewing the Child

Dissociative children can often display subtle shifts when switching from one state to another, particularly if the self-state's age is close to the biological age of the child, making such shifts challenging to detect. Shifts can occur with children who have DID as well as DDNOS. Those with DDNOS can have internal states that influence shifts in the child without taking executive control of the body. Shifts can occur rapidly, making the occurrence difficult to detect and can be subtle.

The following are some signs of shifts:

- Sudden staring or glazed look when talked to
- Rapid blinking, fluttering, or eye rolling without any warning
- Other facial changes—biting lip or a burrowed frown
- Voice changes in tenor, inflection, or language, such as baby talk or demanding adult tone
- Body posture, from relaxed to stiff or from coordinated to clumsy
- Contradictory thoughts noted in the same sentence, such as "I don't get along at all with my mom. We get along alright," or, "I hate soccer. I like playing it"
- Dramatic changes in behavior preferences, such as enjoying drawing in office to hating it
- Shifts in awareness of what was just said by the child or therapist or confusion, discrepancy, or denial of earlier report of traumatic and nontraumatic events

It is important to be aware that even common questions can be triggering to traumatized children. These questions may spontaneously cause dissociation and shifts in self-states, particularly when they pertain to traumatic reminders, such as name of the perpetrator, events or symptoms related to the traumatic event. Exploring what precipitated such shifts is a crucial step in untangling the onset of the dissociative processes. Because dissociative children are often unaware of what prompted sudden changes, meticulous questioning is required to find out what transpired *just seconds before the shifts* (Silberg, 2012). Questions related to what transpired within the child's mind, what bodily sensations are felt, any internal conflicts, internal voices, or any upsetting reminders will provide valuable information about what instigated these shifts. If the child is not aware after questioning, cataloguing these moments and coming back to them later, particularly when a similar shift occurs, may provide illumination. Once the interviewer spends more time with the child, a pattern of such shifts becomes more observant and a complex picture emerges.

These shifts in affect and thought processes can show some evidence of internal confusion or conflict that may relate to some self-states for which the child may or may not be consciously aware. Self-states can have varied preferences to food, dress,

activities, and relationship disparity with parents, siblings, friends, teachers, etc. They can have divergent skill levels in academic and social performances, depending on their age and how they were formed, and their purpose. Some of the shifts may be subtle while others may be more extreme. Dissociative children can switch so rapidly that it is easy to overlook the shifts or attribute them to other reasons, such as the child is nervous, or just has a cognitive impairment. However, it is these shifts that can be clues to dissociation. Questions should be geared to exploring shifts that occur in the session as well as a general exploration of sudden changes or shifts that the child experiences.

Auditory and visual hallucinations should be asked about, as in any mental status exam. If endorsed, then follow-up questions about the details of the hallucinations are recommended that cover frequency, triggers, details of what is said and seen, and impact on the child. When I specifically inquire about dissociative symptoms, I will present these questions in a nonchalant manner, explaining that I have worked with many children that have described similar experiences. I will explain that these experiences occur because of stress and upsetting events. This normalization helps to put them at ease to talk about their hallucinations.

I will often see the child with the caregiver initially to learn what the concerns are and to begin rapport building. It is important to begin on more neutral ground by asking about the child's interests, hobbies, favorite games and television programs, any heroes, or people they admire (Adler-Tapia & Settle, 2008).

At some point in the evaluative process I will ask the child and caregiver to fill out the appropriate dissociative checklists. I will ask the youth to explain items that he significantly endorses.

Silberg (1998) discusses interviewing strategies that can help children reveal their internal experiences. Because it is less stressful for younger children to be engaged in a play activity when interviewed, I will ask them questions about dissociative experiences as they play with toys, dolls, etc. With adolescents who are fidgety, I will provide a squishy ball to hold, drawing supplies, or some other activity that helps the youth feel calmer and more comfortable. Some of the questions are similar to the questions on the dissociative checklists.

The following are suggested questions to explore dissociative symptoms with children and adolescents. Depending on the age and developmental level of the child, modification or reframing of the questions will need to occur. Pace the questions according to the child's ability to manage them.

Some Suggestive Questions to Ask the Youth

- Have you ever had or have imaginary friends? Do they seem real to you? If so, in what way?
- Some kids who have been through similar situations have reported hearing voices either inside or outside of their minds. Have you had that happen to you?

If the answer is affirmative, follow up with these questions:

- Do they seem friendly, angry, sad, scared, etc.? What do they say? How often do you hear them? What is happening just before you hear them? What feelings do you have when you hear them? What thoughts do you have when you hear them? Do you talk to them?

- Do you ever see things, objects, or people and later realize that what you saw wasn't there or you weren't sure if they were there?

If the answer is affirmative, follow up with these questions: Did you hear voices at the time and, if so, what were they saying? Please describe what you saw? When do you see them? How often do you see them? What were you doing, feeling, or thinking at the time?

- Do you find yourself zoning out and not aware of what is happening in the here and now?

If the answer is affirmative, follow up with these questions:

- How often does that happen? What is going on just prior to zoning out? What are you feeling or thinking just before you zone out? For how long does it happen? What is the shortest and longest amount of time? Where do you go in your mind? (Child may not know.) Do other people notice this, like parents or teachers and, if so, what do they say to you? Do you have control over it or does it just happen?
- Do you ever have a hard time recognizing or remembering your parents, siblings, friends, teachers, etc.?

If the answer is affirmative, follow up with these questions:

- When are those times (when wake up in the AM, bedtime, stressful times)? Who do you have a hard time remembering or recognizing? Do you hear voices at that time? What are you feeling and thinking then? How often does this occur? Do you tell anyone about those times?
- Do you have a hard time remembering what you did, like homework? Do you get homework back and not remember you did it? Or not remembering drawing, playing games, doing chores, or doing other activities, but others indicate you did those activities?

If the answer is affirmative, follow up with these questions:

- Can you please tell me about those times? How often? What seems to be occurring at those times that may have something to do with not remembering? Are you mad, under stress, having a conflict? Do you hear any voices or see things inside of your mind or outside of your mind that may not be there later when you are having problem remembering?
- Do you have a hard time remembering scary or bad things that happened to you?

If the answer is affirmative, follow up with these questions:

- Can you tell me about them? (Be aware that you may not want to pursue too many details about trauma, as the child may not be ready to disclose or be strong enough to handle the disclosure. You may witness some dissociative shifting, which is diagnostic. Notice the child's reactions and follow sound therapeutic guidelines and principals.)

Keep in mind that these questions can be asked throughout the evaluation process and also during the treatment phase as indicated. They are only a starting point to further explore amnesia, trance states, and other dissociative experiences.

When I first met Lisa, we sat on the floor and played with the dollhouse while I asked general questions about what she liked to do, etc. Then I asked about memory problems. She reported that it takes a while for her to remember her parents and siblings and that she is accused of doing things that she does not have any memory of doing. She endorsed hearing voices that sounded like a baby and another one that was garbled. I reassured Lisa that other children have reported similar experiences and that I knew how to help them with those experiences. The next morning, I received a phone call from her mother. She excitedly told me that after the session, Lisa went back to the waiting room, sat down next to her mother, and for the first time, looked at her mother's eyes and smiled. Her mother was thrilled that Lisa did not have "that blank look" on her face! Mother hugged her daughter. This report confirmed that my questions and reassurance had opened a door for Lisa to begin to heal. She appeared relieved to finally have someone who understood her.

OTHER COLLATERAL INTERVIEWS AND COLLATERAL REPORTS

With appropriate releases, it is invaluable to contact teachers, school and past mental health counselors, medical and legal personnel, child protective services, and other professionals to garner pertinent information regarding traumatic history, previous diagnoses and failed treatment experiences. Traumatized children, who have a lengthy history of ineffective psychopharmacological and clinical treatment episodes, often have underlying dissociative processes that impact their resistance to standard therapies.

Principals and teachers are frequently the first to detect clear signs of dissociation with their students, which is critical to my diagnosis and treatment design (Waters, 2011), noting amnesia, trance behaviors, and extreme mood switches. When I have a child displaying dissociative symptoms, I will refer educators to the website of The International Society for the Study of Trauma and Dissociation's Child and Adolescent FAQ for Teachers (<http://isst-d.org/education/faq-teachers.htm>). I will then follow up with further consultation with teachers and school counselors to discuss the signs and effective strategies to decrease children's dissociative behaviors in the classroom.

Consulting with child protective services and police and receiving their investigative reports can provide a chronology of trauma and related anniversary reactions. Explaining signs of dissociation to investigators can assist them to formulate a more accurate understanding of the child's trance behaviors or inconsistent reports. I will refer child protective service workers, forensic evaluators, and lawyers to a training DVD (Waters, 2007) for further understanding dissociative children's responses.

I collaborated with Lisa's chiropractor, informing her of my assessment of Lisa's infant self-states and our complimentary work. She was intrigued and receptive. She had Lisa do a series of core strengthening and bilateral integrative exercises that helped Lisa cross over her midline in opposite directions with her head and arms. When I worked with Lisa on age progressing the infant self-states, there was a dramatic improvement in her ability to do these exercises. She was finally able to open bottles and adequately hold silverware.

I consulted with the adoption agency about Lisa's complex presentation that required specialized treatment for dissociation and requested their financial support for her intensive treatment, which was granted.

Because Lisa was no longer acting out at school and being sent home, I did not need to consult with her teacher. I monitored Lisa's academic progress through regular reports from her mother.

CLINICAL SUMMARY AND CONCLUSIONS

This case highlights how trauma can have a profound impact on a helpless baby who has no recourse but to escape by dissociating (Liotti, 2006, 2009; Solomon & George, 1999). During evaluation, EMDR clinicians need to gather extensive early history of any trauma and recognize that infants are "not too young to feel," and reliance of dissociation is an effective escape for them.

When assessing children, examining the efficacy of past treatment episodes can provide a clue to any dissociative processing that may account for treatment failures. In Lisa's case, standardized, acceptable, or questionable therapeutic interventions unwittingly increased her dissociation. Her medication was ineffective in affect regulation due to her dissociative mechanisms. Holding therapy had an adverse impact on Lisa's ability to build attachment with her mother and appeared to escalate her dissociative responses. Behavioral therapy was ineffective as her dissociative states controlled her behavior. Without identifying their presence and roles, behavioral consequences or rewards had little meaning in rectifying her disturbing behavior.

As in Lisa's case, dissociation should be considered when traumatized children display splintered abilities, regressed or developmental delays, trance behaviors, extreme mood switches, and memory problems. Past treatment failures warrant further exploration of underlying dissociative mechanisms that may be thwarting progress.

Finally, but critically important, Lisa's safe environment and her astute, empathetic, and conscientious mother, who kept copious notes tracking Lisa's mercurial presentation, were instrumental in evaluating the presence of her dissociative states.

Early unrecognized and untreated dissociation can be devastating. Children and adolescents who dissociate can be prone to a lifetime of debilitating symptoms. While traumatized children present a convoluted picture that can easily be misinterpreted and misunderstood due to a plethora of shifting symptoms, it is such complex, mercurial presentation that is characteristic of dissociation. EMDR professionals should not be sidetracked by the symptoms alone and miss the underlying dissociative processes that play a central role in maintaining the symptoms. Otherwise, dissociative children will continue to experience impairment in identity, memory, and perception of the environment that will hinder their ability to reach their potential.

Early identification of dissociative processes is a paramount step to design an effective treatment course, along with a safe environment, that will nourish the child's ability to release dissociative mechanisms. This will pave the way for the dissociative child to become a unified self who is able to pursue a fulfilling life.

After Lisa suffered nine turbulent years of severe depression, confusion about herself and her surroundings, constant triggers of early traumatic reminders, several assessments and failed interventions, her dissociative symptoms were recognized. Asking simple but potent, relevant questions were critical to uncovering her dissociative defenses that severely contributed to her persistent and debilitating symptoms. Lisa's recovery can now begin.



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Prevalent, but often times overlooked, are the co-morbid symptoms of obsessive-compulsive behaviors in traumatized, dissociative children. Traditionally, Obsessive Compulsive Disorder (OCD) has been viewed as an isolated diagnostic entity, void of the contextual relationship to traumatic memories. Historically, OCD has been treated with medication and/or behavioral therapy with minimal efficacy or permanent results, resurfacing as an intense battle within the child, and a persistent struggle between child and parents. While these therapies have value for many who suffer with OCD, for the traumatized child, they do not uncover the underlying trauma-based formation of this disorder, the unconscious processes involved, and the continued purpose that the obsessive-compulsive behaviors serve.

In the past 20 years, as I have intensively studied and treated traumatized children with OCD symptoms, from pre-verbal through adolescence, I began to understand dissociation as a means to escape trauma and its sequelae, and its association with obsessive-compulsive behaviors. This understanding has paved the way for effective intervention with my clinical cases.

The origin of OCD in traumatized children appears to be linked with the traumatic experience. The onset of these symptoms may surface at the time of the trauma, or related trigger, and become contained within ego states or alter ego personalities which developed to cope with the overwhelming affect, cognition and associated behavior. This is a dissociative process, and therefore, uncontrollable, until the state-dependent ego states or personalities are accessed. (Waters & Stien, 1999). In my clinical cases, these symptoms have persisted until the ego or personality states, the traumatic memories, and the purpose served by the obsessive-compulsive symptoms have been uncovered and treated. If not treated psychodynamically, the symptoms may continue to cause extreme distress for the child, and consume his/her life.

I have noted several purposes that the obsessive-compulsive behaviors may

serve for the dissociative child. They may soothe or comfort the child due to a lack of protection or support at the time of trauma, e.g. the DID (Dissociative Identity Disorder) adolescent who had engaged in compulsively rubbing silky fabrics continuously throughout the day to soothe herself from the time she developed a preverbal alter personality at the time of the trauma.

Through nonsensical rituals, OCD may provide a distraction and avoidance of intense affect, undesirable behaviors or intrusive traumatic memories. A clinical example is a nine-year-old DDNOS (Dissociative Disorder Not Otherwise Specified) girl who engaged in finger tap-

A careful assessment of the etiology of OCD symptomatology in traumatized children is crucial for meaningful intervention.

ping and counting as an attempt to avoid and distract from persistent, intense shame and guilt. These symptoms were contained within a shame-based ego state developed when she was sexually victimized, and reinforced when she sexually engaged with peers. In addition, she used compulsive finger tapping and counting as an escape from distressing and disturbing obsessive thoughts to look at male and female genitalia. Her OCD was clearly a desperate attempt to avert the intense and disturbing sexual obsessions and compulsions.

OCD may attempt to regulate and manage intense and undesirable affect that does not have an appropriate expression. An example is a dissociative child who compulsively hand washes and showers to cope with feeling dirty as a result of the sexual abuse, and other unbearable feelings of shame, guilt, anxiety, rage, etc. contained within her personality states.

OCD may serve as a symbolic reenactment of traumatic events, as with a small child who has a sexualized alter who masturbates compulsively until he bleeds, while in a trance state, complete-

ly detached and depersonalized from the injury he is incurring on his body. Another case example is a 16-year-old DID female who had a promiscuous alter personality reenacting her sexual abuse through compulsive sexual behaviors with a multitude of partners.

A careful assessment of the etiology of OCD symptomatology in traumatized children is crucial for meaningful intervention. Examining the onset of these symptoms and their link to traumatic memories, the containment of these symptoms within the child's dissociative states, and the purpose these symptoms serve the child in managing the traumatic memories, affect, cognition and behavior will provide a pathway for effective treatment.

Waters, Silberg, and Putnam's approaches to treating other symptoms with dissociative children (Waters & Silberg, 1996; Putnam, 1997) are also applicable to successfully treating OCD. In summary, these approaches include: accessing the dissociative personality states that contain the OCD; developing co-consciousness, cooperation, and an understanding of the original purpose such behaviors serve in the traumatic experience; careful processing the memories on all domains; and replacing the obsessive-compulsive behaviors with healthy coping mechanisms (Waters & Stien, 1999). Medication and behavior therapy can be adjunct modalities to assist the dissociative child, but, by themselves, are ineffectual in eliminating OCD.

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From the President

Atypical DID Adolescent Case

This is an atypical DID (Dissociative Identity Disorder) adolescent case noteworthy because of a singular, obscure precipitating traumatic event reported occurring in an apparently "normal family", the child's increased emotional vulnerability to dissociate because of insecure maternal attachment, the rapidity of recovery due to the parents' support coupled with the early detection of and successful intervention with dissociative states. During this time-limited evaluation, the use of dissociative checklists expedited the evaluation process, which was filled out prior to the evaluation. They included the Adolescent-Multidimensional Inventory of Dissociation (A-MID) (Dell, 2004), the Adolescent Dissociative Experience Scale (ADES), (Armstrong, et al, 1997), and the Trauma Symptom Checklist, (TSC) (Briere, 1996).

Sarah Doe, 17 years old, was referred to me by her mother for an evaluation due to the presenting diagnoses of dissociative amnesia and Eating Disorder NOS, provided by her treating psychiatrist and clinical psychologist. Because her intact family resided in another state I did an extended evaluation and intervention techniques lasting nine hours over a day and half. Both of her parents and her only sibling, a college-age sister, participated in the evaluation.

When evaluating Sarah, I utilized the Quadra-Theoretical Model for Assessing and Treating Dissociation in Children (Waters, 1996), which is a diamond shaped model integrating four theories: attachment (at the apex of the diamond because of its significance), family, developmental and dissociative.

The first day of the evaluation, I initially met with the entire family to gather significant childhood developmental history, some family history, their description of Sarah's presenting symptoms

and to observe family interactions. I then met with Sarah individually for most of the day, concluding with another family meeting to discuss current findings, with Sarah's approval. The second day began with a meeting with Sarah and her parents to review the prior evening. I resumed meeting individually with Sarah, and then concluded the evaluation with the entire family summarizing my impressions and recommendations. This was followed by a short individual session with Sarah's mother to recommend individual therapy.

Sarah was a pleasant, attractive, 17 year old young woman of average height, weighing 100 lbs and in the eleventh grade. Initially, she presented with a flat affect and significant confusion about

During this time-limited evaluation, the use of dissociative checklists expedited the evaluation process

her life. With occasional brief moments of spotty memory, overall, Sarah described complete amnesia for her present daily life, including parents, home and academic environments, year long boyfriend, and peers. She had some recognition of her sister, who was three years older. She did not recognize her therapist or recall their weekly sessions. An exception to her amnesia was Sarah's recollection of childhood friends as early as three years old until around seven years old, and her deceased paternal grandmother, with whom she had been very close.

The onset of her dissociative amnesia occurred after she had received outpatient treatment for a year and was recently discharged from an inpatient

treatment program for an eating disorder. Shortly after her inpatient release and after celebrating a school sporting banquet with her family and sisters, she began to faint repeatedly and was taken to the local hospital emergency room with complete amnesia. While in the ER, Sarah experienced severe pain in her ankle and could barely walk. Numerous exams and X-rays found no organic cause, but she limped for several weeks with prologue pain.

Regarding Sarah's history, she came from a middle class family with parents who were involved in her activities. She described herself as a daddy's girl, a tom boy, compliant, distant from her mother, and close with her accomplished sister whom she emulated. Since Sarah's amnesia, her mother has been emotionally attentive and their relationship has consequently strengthened. Throughout her high school years, Sarah was a class leader, high achiever, popular, and involved in many extra-curricular activities. She described herself as a pleaser,

She described internal auditory hallucinations of a "little girl," a "critical part," and a "control part."

and unable to refuse participation in any civic program. Sarah would appease her friends at any cost to avoid arguments, and apologize even when she wasn't culpable. She would "bottle up" any negative affect. Sarah denied any form of child maltreatment or abuse and indicated that her parents had a good marriage, void of domestic violence and thus presenting a clinical puzzle about what triggered such amnesia and suspected splitting of consciousness. Regarding any losses, Sarah's paternal grandmother had died four years earlier. Her death was very difficult for the entire family, including Sarah's mother, Patricia, who viewed her mother-in-law more of a mother to her than her own mother who had a lengthy history of psychiatric hospitalizations, beginning at Patricia's own birth. I suspected that Patricia's own unresolved maternal attachment issues contributed to the distant relationship with Sarah.

Given how debilitating Sarah's life had become in the last several months, i.e. barely able to function in school, an accurate assessment and therapeutic intervention to alleviate Sarah's amnesia was paramount. As I began to educate about and to explore with Sarah her severe amnesia, she was articulate, open and motivated to understand herself and to be understood, thus forming an immediate rapport with me. She described internal auditory hallucinations of a "little girl," a "critical part," and a "control part." She displayed significant insight about her internal states and with careful questioning the dynamics of her splitting was unveiled. The seven year old "little girl" was the only one who had taken executive control over Sarah, while the

other two self states remained internal but driving Sarah's feelings, thoughts and behaviors. Although a variety of trauma related questions were asked, Sarah denied any traumatic event during the first day of the evaluation which might account for such fragmentation when she was seven years old.

Nevertheless, a clear description emerged regarding the functions of her self states as she described in detail being plagued by the internal voices', conflicting, contradictory messages.

Sarah had been highly driven with an enduring desire to please and to be "perfect" due to fear of angering anyone. She felt a commitment to fix everything, whether it was realistic or feasible, and emulated her older sister's achievements and abilities. Consequently she "stuffed" her feelings to meet these expectations. She was developmentally reaching a critical age as a 17 year old in which individuation and separation are further decisive developmental milestones to prepare for adulthood. However, as Sarah faced this developmental crisis, the emerging needs of the hidden "little girl" began to surface until she took full control of Sarah. The "little girl" wanted to play, relax and have fun, which had become an anomaly in Sarah's life, due to the persistent "Critical One," who would tell her to do more and to do it perfectly, join every civic group available, get straight "A's" etc. In order to resolve this intense conflict, the "Control Part" was created to essentially take control of the situation and protect the "Little Girl's" wishes. The main mechanism that the "Control Part" used was to take away Sarah's memory, which allowed the "Little Girl" to emerge to meet her desires to play and have fun. In addition, the internal presence of the "Little Girl" played a central role in Sarah's year long anorexia because Sarah kept seeing herself as needing to be little, through the eyes of the hidden "Little Girl." So she starved herself. The triggering event which prompted the child state to take executive control over Sarah occurred after the sports banquet when Sarah ate with trepidation and recreated the irresolvable struggle of the Critical Part telling her to eat, while simultaneously fearing "getting bigger," and seeing herself as little through the influence of the "Little Girl." The "Control One" decided to resolve this dilemma to protect the interest of the child state by removing Sarah's memory and power.

Through a dissociative treatment framework combining psychodynamic and cognitive approaches, immediate extensive cognitive reprocessing, reframing, and cooperation occurred between Sarah and her self states. A contract was established in which the "Control One" agreed to give back Sarah's memory if Sarah consented to relax more and have fun, which would meet the child state's need. Sarah quickly accepted that growing up doesn't mean that one can't have fun and that to retain the child-like qualities of spontaneity and playfulness are crucial to a healthy adult lifestyle. The "Critical Part" agreed to be renamed "Advisor" and accepted that it is impossible to be perfect and to please everyone. "Advisor" was encouraged to relax and to help Sarah set realistic expectations and limits and to

encourage assertiveness.

The second morning of the evaluation, there was a marked improvement in Sarah's affect, memory, appearance, and overall outlook. Sarah remembered the entire first day of the evaluation, and her parents were delighted that Sarah had joked with them and recalled spontaneously information the previous evening.

The precipitating event that caused Sarah's dissociation was a mystery until I queried her further, suspecting that it pertained to her fear of expressing anger. Although she had previously denied any parental domestic violence, I reframed the question asking, "Was there any arguing between your parents or anyone

Parents understood that since they had aged and their house was completely remodeled, the child state did not recognize them or her home

else that had scared you or upset you?" She immediately reported a continuous vivid memory at seven years old witnessing an altercation between her parents when they returned home from a party, screaming at each other. Her father hit the wall with his fist and then left, leaving her mother crying. Since she was daddy's girl and not close to her mother, Sarah immediately experienced loss and abandonment, even though he returned the next day. Her parents never spoke of this incident, nor was Sarah able to receive comfort and reassurance to overcome her lingering fear of losing her dad, who was a powerful figure in her life. Even though this was an isolated incident, it shattered her security and contradicted her belief that she had a perfect family. This pivotal traumatic incident appears to have prompted her to dissociate and to drive her to perfectionism to avoid reexperiencing loss and abandonment. (Although with further assessment, it is possible that Sarah may have delayed recall of additional trauma.)

In exploring Sarah's painful ankle and persistent limping, without any organic cause, when she was taken to the ER at the time of her full blown amnesia, I queried her about any injuries. She smiled, realizing the connection to an incident when she was seven years old when she had fallen from a tree, was taken to the ER, and diagnosed with a badly sprained ankle causing her to limp for several weeks. When the child dissociative state emerged and once again was taken to the ER, this triggered the painful memory of her sprained ankle. Sarah was educated about somatoform dissociation (Nijenhuis, 1999).

Given the speed of our evaluation and Sarah's dissociative states' willingness to cooperate and integrate, I did a fusion exercise through hypnotic suggestion to age progress the child

state to Sarah's age and then the three dissociative states fused with Sarah. I made two audio tapes with Sarah on visualizing an internal safe place when she feels overwhelmed and a sensory psychotherapy exercise modeled after Grove and Panzier (1991) to help her resolve negative bodily sensations related to her eating disorder. She was encouraged to listen to them when she returned to her community for follow-up treatment.

Regarding the ratings on the checklists, Sarah presented on the A-MID with atypical dissociation, rating high on symptoms of amnesia, reported child and angry alters, and met the criteria of Dissociative Identity Disorder (DID) without Posttraumatic Stress Disorder and with low negative affect. Dell evaluation suspected that Sarah "lost" her host personality as a result of something unknown (her lack of reporting a traumatic event.) The A-MID provided accurate and pertinent details, which matched my clinical impressions. Sarah scored a 4.06 on the A-DES, which met the criteria for a Dissociative Identity Disorder, which I concurred. However, on the TSC, Sarah scored in the high range on the under-response scale, thus denying behaviors, thoughts, or feelings that most others would report at some level, and scored below clinical symptomatology on all of the clinical scales, including dissociation. It is difficult to ascertain her underreporting but it may pertain to a dissociative state's influence when filling out this checklist.

At the conclusion of the evaluation, Sarah and I informed her family about the cause of her splitting, and the subsequent integration of dissociative states. We made an agreement for Sarah and her mother to engage in activities to enhance a healthy attachment and a follow-up plan. Parents understood that since they had aged and their house was completely remodeled, the child state did not recognize them or her home.

I then met privately with mother to encourage her to seek individual therapy to work on her unresolved attachment issues with her mother, who was unable to adequately parent her due to lengthy severe mental illness. It was difficult to ascertain at this evaluation what mother's own history of attachment problems was. One can surmise that she may meet the criteria for having Disorganized Attachment. There has been much in the literature about the relationship between disorganized attachment and dissociation (Liotti, 1999; Lyons, 2003; Ogawa, et al, 1997). Mother's responses toward Sarah, particularly when she was younger, which may have been frightening, confusing, contradictory or dissociative, could be indicative of a second generation of disorganized attachment contributing to Sarah's own dissociation. This phenomena is described in Schuengel, et al. (1999) article.

Due to a lack of a specialist in dissociation in Sarah's community, she saw a generalist, who primarily worked with her on her eating disorder but unfortunately did not contact me for consultation. However, I did periodic follow-up calls with Sarah and her mother. After three months, Sarah still maintained her

continued on page 5

memory and integration, and was eating properly. At a nine month phone follow-up, Sarah's condition had deteriorated. She had gained 40 lbs. (partly due to a prescribed anti-psychotic medication, Zyprexa, known to cause significant weight gain), had recurring voices, and depression which was prompted by the unexpected, traumatic breakup with her boyfriend of two years, who had been extremely supportive during her amnesia. This triggered recurring loss and abandonment issues, and splitting again of the Critical/Advisor Part and the Control Part. However, the age-progressed, child part remained integrated. Sarah resumed self-degradation and self blame even though no specific event precipitated the breakup. She experienced only a few, five-minute incidents of amnesia and disorientation at school when she became angry. She reported not feeling close to her therapist who did not question her about any dissociative symptoms. Sarah wanted to tell her therapist about the recurring voices and call me for help, but she felt "stupid."

Parents immediately agreed to return Sarah to see me for follow-up intervention. I saw her for three hours. Sarah once again reprocessed erroneous beliefs about her culpability in the breakup, loss and abandonment feelings, perfectionism, and fear of growing up connected with some enmeshment with her mother. Her self states agreed to integrate. Sarah recognized how she was literally stuffing her feelings with over eating. Importance of locating either a therapist specializing in dissociation within driving distance or a commitment from her treating therapist to collaborate with me was stressed. Phone consultations and a two month follow-up session were arranged with me.

This case highlights critical factors in treating adolescents. First of all, when a child is in a safe environment with parents who are overall attentive and caring, regardless of some family history of pathology, children are more likely to benefit from intensive intervention. The early discovery and management of fluid dissociative states in children can prevent them from solidifying and can make rapid integration more feasible, thus preventing adult years of dysfunction. A positive transference with the therapist is critical for facilitating the recovery process. Exploration of impaired parent-child attachment relationships as a "precursor" or proclivity to dissociate should be analyzed, predominantly when there is fear of loss and abandonment coupled with witnessing domestic violence, or experiencing other forms of trauma, particularly given current research showing the relationship between dissociation and Disorganize Attachment. When the child does not receive comfort, a singular and/or obscure traumatic incident should be explored as to the impact on the child's coping mechanism. Traumatic inci-

dents may not always be reported initially by typical abuse related questions, which means astute, subtle questioning may be required to elicit important information about trauma. Additionally, the treatment process should include ongoing assessment for possible further traumatic disclosures. A developmental crisis may spur the child to find escape through dissociation, if other conditions exist. A family history of mental illness may create some physiological vulnerability for a traumatized child to dissociate. The use of dissociative checklists can be a valuable adjunct to the evaluation interview. Finally, consultation regarding evaluation and follow-up treatment with a skilled clinician in dissociation is paramount for the child to maintain growth, integration, and appropriate medication.

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Inside:

Science of Childhood Abuse	8
Record-keeping / HIPAA	11
Electronic Voting	16



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From the President

Recognizing Dissociation in Preschool Children

As I look out the window of my Northern Michigan home, it's the beginning of the blooming season, which occurs in late May here. I admire the spring flowers while pondering their indomitable ability to survive in spite of the frigid winds and heavy snow that blow off of Lake Superior. I am always amazed to see the delicate tender shoots of crocuses that emerge when this snowy Northern landscape finally thaws. As a weekend gardener, I realize how delicate yet tenacious the tulips, primroses and daffodils must be to bloom once again. However, upon closer scrutiny, I notice that some of the daffodils' stalks are green but there are no golden flowers atop. I don't really know why they didn't bloom this year, but I am reminded how vulnerable flowers are to a severe environment. To maximize their beauty and strength, just the right amount of water, sun, rich soil and, of course, fertilizer are needed. Absence of one of these environmental elements can leave the plants dwarfed and fragile, or not blooming at all. The development of these early bloomers is susceptible to a myriad of factors, genetic and environmental, the later in particular either nourishing or inhibiting their growth.

As I ponder the emerging beauty of the spring and the intricate balance it reflects, I recognize how symbolic it is of the right amount of nourishment, security, and stability required in a child's environment for healthy growth and a strong identity. The vulnerable young children I have treated over 30 years have experienced turbulence, unpredictability, and repeated traumas leaving them fragile, dissociated, and undeveloped without exuberance like the daffodils without their flowers.

In the past, there was scant literature on preschool childhood dissociation (Riley & Mead, 1988; Silberg, 1998; Shirar, 1996; Putnam, 1997; Macfie, et al., 2001a; Macfie, et al, 2001b; Haugaard, 2004) but since the development of the

classification of Disorganized (D) Attachment (Main & Hesse, 1990, Main & Solomon, 1990), there has been more attention to this population, as dissociative responses are characteristic of D attachment with infants and toddlers. They display a disorganized, chaotic response to their parents marked by wanting to reach out to them, while switching to freezing, staring off, backing away and/or collapsing when the parent approaches (Solomon & George, 2001). The theoretical conceptualization that D attachment may lead to the development of a fragmented self (Liotti, 1992, 1999a, 1999b) appears to be supported by longitudinal studies showing that children with avoidant or D attachment may develop dissociative

Very young children can neither soothe nor protect themselves, and do not have the mobility to seek out another caregiver.

characteristics (Ogawa, et al. 1997, Carlson, 1998). The research examines various attachment styles, and the mother-child relationship as a mediator or predictor of the development of dissociative symptoms in the child. Avoidant or disorganized attachment may in turn predispose the child to a dissociative response to trauma (Barach, 1991; Liotti, 1999a, 1999b).

Also, research indicates that infants and very young children are more prone to dissociate because they don't have the coping mechanisms to handle fearful or stressful situations independently (Solomon & George, Eds., 1999, Perry, 2001; Lyons-Ruth, K., 2003; Lyons-Ruth et al, 2004;

continued on page 2

Ogawa, et al., 1997, Carlson et al, 1989). The attachment system motivates the child to approach the parent whenever distressed. Very young children can neither soothe nor protect themselves, and do not have the mobility to seek out another caregiver. If a parent responds in a frightening or contradictory manner, the child can neither approach the caregiver for comfort nor flee the very person on whom his life depends. The child's limited cognitive and behavioral systems for maintaining attachment may break down, leading to dazing, confusion, and rapid alternation between approach and avoidance. These disorganized responses appear to activate the neurophysiological mechanism which involves dissociative adaptive response, i.e. staring, unresponsivity, hypalgesia, depersonalization, and derealization (Perry, 2001). This calls for clinicians to be particularly heedful of dissociative indicators in infants and young children given their neurobiological capacity to dissociate when in the face of persisting threat. Yet, the significance of their responses

It is important to consider whether their regressed behavior is indicative of a younger dissociated state.

often continues to be minimized or misinterpreted (Waters, 2005) because professionals erroneously believe that this population, contrary to current research isn't affected by frightening or/and unresponsive caretakers. Understanding symptoms of disorganized attachment are crucial to early detection and intervention of dissociative processes with preschool children.

The following are some prominent indicators of dissociation (Putnam, et al, 1993) in preschool children followed by an analysis of a case study.

- Staring, spacing out or trance-like states, including inattention
- Amnesia
- Extreme fluctuations in emotions and behaviors, including "regressive behaviors"
- Dissociative states or self states, including internal voices, referring to self in third person, and the importance of distinguishing between imaginary playmates and dissociated self states

I poignantly recall the first preschool case that I diagnosed in 1988 with Dissociative Identity Disorder, before the development of the Child Dissociative Checklist (Putnam, et al, 1993) and much published literature on the subject (Kluft., 1984; Kluft., 1985). Katie¹ was a bright and articulate three year old child in foster care whom I had assessed, treated and for whom I subsequently submitted a court report. Over time, she disclosed to me multiple traumatic events, i.e. sexual abuse by mother's boyfriend at 3 years old, and later disclosed sexual abuse by her biological father (convicted of sexual abuse of an

older daughter) when she was a year and a half old. She was also neglected, and physically and emotionally abused by her mother and mother's boyfriend.

Katie would sit for extended periods of time staring into space and non-responsive. She would talk out loud to herself referring to herself in the third person. She displayed extreme shifts in mood and behavior marked by sudden angry outbursts over minor requests, uncharacteristic of her usual pleasant behavior. During these outbursts, she would attack her younger brother and then adamantly deny it, crumbling on the floor and extremely distraught that she was unfairly accused. At other times, she would regress into baby talk, particularly after supervised visits with her biological mother. She had episodes in the morning in which she would frantically try on different clothing, particularly underwear and slacks, crying hysterically stating that "Nothing felt right." No amount of prior agreed selection of an outfit or any reasoning was able to prevent her from escalating into hour-long episodes of chaotic, disoriented behavior to resolve what to wear. Meal times were occasionally stressful because she would suddenly not like her favorite food, macaroni and cheese, and would want something else to eat. She had severe insomnia and would literally hold open her eye lids to deter herself from going to sleep for fear of reoccurring nightmares. Most of these symptoms were exacerbated after visits with her biological mother.

My epiphany occurred (when I realized that Katie had Dissociative Identity Disorder) when she was in one of her 'regressed states' crawling on the floor engaging in baby talk and mumbling that she needed "to potty." She extended her hands for me to carry her to the bathroom, which I proceeded to do. When we entered the lobby where her foster mother of 6 months was waiting, I paused with Katie in my arms to inform her foster mother that we were on our way to the bathroom. Katie looked frightened at the 'stranger' and turned away refusing to talk to her stunned foster mother while wrapping her small arms tightly around my neck. Although I had been recognizing and diagnosing older dissociative children for a few years at this time, I misconstrued Katie's younger dissociative state as 'regressed behavior.' When, I reviewed the court report, I found that I had indeed described such behavior, i.e. baby talk, crawling, but had not recognized the significance of what I had seen until I witnessed Katie's amnesia for her foster mother. It was at that pivotal moment when the true meaning of her behavior crystallized for me in an accurate diagnostic picture.

A reconceptualization of Katie's misunderstood, regressed behavior and other symptoms opens the door to discussing multiple challenging factors involved in accurately assessing preschool children for dissociation. For a variety of reasons, it is frequently difficult to understand the meaning of young children's dissociative behaviors. It is important to consider whether their regressed behavior is indicative of a younger dissociated state. The evaluator needs to distinguish developmen-

¹Client's name is a pseudo name

ISSD Psychotherapy Training Program Launches New Initiatives

The Dissociative Disorders Psychotherapy Training Program (DDPTP) is proud to announce the addition of new Directors, new Programs, and new plans for expansion of our efforts. We've got a good thing going, and we are determined to make it better. We are proud to be able to offer a high quality educational experience for member and non-member clinicians and to "level the playing field" through educating ourselves and our peers. The dividend this reaps for current and future patients is a wonderful thing.

New Directors

Originally, Liz Bowman and Rich Chefetz shepherded this course into existence based upon the eleven month long course Liz taught from her office in Indianapolis. Each year, the Basic DDPTP has had around 18 face-to-face seminar sites in North America, Europe, and the Middle East. Steve Frankel joined Liz and Rich as a Director, two years ago, and has now completed the design and piloting of the Advanced DDPTP, to be offered next Fall at a number of locations (see below). The online course that Rich designed now has two sections running concurrently, but staggered with a Fall start and a Winter start. Over 50 students are working online at a given time. There has also been active planning to add a modular course to teach an Introduction to the Dissociative Disorders without the current requirement that participants have already treated someone with a dissociative disorder. We are hoping to teach this via the internet, using streaming video, and the course is very early in development. In addition, we have been talking with Daniel Mosca and Eduardo Cazabat, in Buenos Aires, about creating a Spanish version of the Basic DDPTP. With all this happening, two more Directors were added in the Spring with approval by the Executive Council. Both are well known teachers, Elizabeth Howell, and Eli Somer.

Elizabeth will take over responsibilities for the basic DDPTP course, and Eli will work on development of courses to meet International needs. We anticipate waiting for his presidency to end before he gets fully up to speed on that task.

New Courses

We are pleased and excited that the DDPTP-A (Advanced) has been piloted in two locations: Davis, CA (with Steve Frankel) and Cincinnati, OH (with Don Beere). Based on the reactions to the course by participants and faculty, we are planning to offer the Advanced Course at between five and seven locations, beginning fall, 2005. As of this moment, we have definite plans to offer the Advanced course in Chapel Hill, N.C., Montreal, and New York, with strong possibilities in Duisburg, Germany, Washington, DC, the UK and San Francisco Bay area. The Advanced Course has been designed to build upon the material learned in the Basic Course and is also open to experienced clinicians with permission of faculty. Emphasis is on selected readings and extensive case discussions, with senior faculty colleagues facilitating the course meetings.


The Directors are currently negotiating with Fran Waters and Joyanna Silberg regarding their launch of a pilot for a Child and Adolescent DDPTP. The initial pilot will be offered in the Upper Peninsula of Michigan by Fran, and in Baltimore by Joy. A number of options for later multimedia and web casting versions have been discussed in a preliminary manner. In all these discussions the focus has been on how to deliver these educational products to the widest number of people at the same time that we don't burn out our faculty. It is an interesting and exciting process.

Expanding Efforts: It seems like there is increasing interest in the online sections as well as the possibility of additional online distribution of course seminars through streaming video. The technical specifications are coming more and more within the reach of lower budget operations, like ours, and as always, there is the factor of maintaining the "people power" behind the efforts that make all this possible. The DDPTP has been blessed with a lot of hardworking faculty, and great sup-

port at Headquarters from Michele Biesiada. We're always trying to improve our products and be responsive to students and faculty.

Fall 2005 and Beyond

To see where the sites for the Basic and Advanced Courses will be, take a look at www.issd.org under *For The Professionals: Psychotherapy Training*. By the time you read this newsletter, registration will be open for our Fall classes, including the online section, which will be a Basic class in the Fall, and perhaps an Advanced class in the Winter. We invite you to participate, and to tell a colleague, especially if they are not an ISSD member, about our programs, and invite their participation. Special discounts are available for first time membership and course registration. The DDPTP will have a presentation during the Toronto meeting, so come by and talk with us about learning about the dissociative disorders in the DDPTP community!



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tally inappropriate behavior that may, for example, be an imitation of a new baby in the home from sporadic or frequent extreme switching of atypical behavior, particularly when accompanied by amnesia. Some young children may not exhibit such behavior on a regular basis but the significance of aberrant behavior must be examined carefully, particularly if the child has a trauma history. Katie was an articulate child with good, expressive language. When she uttered singular words and crawled instead of walking, I was struck with this unusual behavior.

For example, Katie's adamant refusal to eat her favorite food is not in itself unusual for children who display oppositional responses, particularly when tired, sick or simply wanting to

Children's triggers may be disguised by their strong oppositional reactions, but a clinician must not assume that the traumatized child simply wants her way

assert independence. However, what is often characteristic of dissociative children is the extreme degree of such changes in preferences and the accompanying intense affective response. Dissociative children will often become inconsolable and quickly deteriorate.

Katie's frenzied search to find comfortable and acceptable apparel was another clue to some dissociative switching among self states. She was able to identify these self states, ranging in ages from one year old to adult, the latter representing her abusers. There was an internal struggle with her self states to take control over what to wear. In addition, Katie's comment, "Nothing feels right," pertaining to anything binding in her abdominal and genital areas was a traumatic reminder of her sexual abuse. I have observed repeatedly this hypersensitivity to clothing in traumatized children who are triggered by sensory stimuli.

Children's triggers may be disguised by their strong oppositional reactions, but a clinician must not assume that the traumatized child simply wants her way. Also, the child's staring, inattention and/or frenzied activity may be misdiagnosed as Oppositional Defiant Disorder or Attention Deficit Hyperactivity Disorder. If professionals focus primarily on these disruptive behaviors without understanding the contextual relationship between parent and child, as well as the underlying connotations, they may miss their true significance. Then if they employ a strictly behavioral approach, it is likely to be ineffectual. The occurrence of maltreatment and the resulting dissociative mechanisms may easily be overlooked and at worst persist.

Katie's amnesia for aggression toward her brother reflects a frequent indicator of dissociative children, one often misunderstood. Dissociative children's amnesia for assaultive behavior or

"forgetfulness" can easily be misconstrued by weary, frustrated, and angry caregivers who assume that their children's denial is an escape from responsibility for their behavior. After dissociative children receive consequences for destructive acts, they will frequently persist in their denial of such behavior even though there isn't any benefit for them to continue. They may also repeat similar aggressive behaviors and be unresponsive to appropriate child management techniques. When astute clinicians see the entire picture of the pernicious impact of child maltreatment, they can understand that disavowal of behavior that others have clearly witnessed is one of the features of dissociation, rather than assuming that the child is simply defiant.

Katie's amnesia toward her foster mother was a potent and florid indicator of a separate dissociative state, rather than regressed behavior. This leads the discussion to discerning between imaginary playmates, fantasy play and dissociative states in young children. Research indicates that at age three, children can distinguish fantasy from reality (Harris, et al, 1991). The formation of separate self states to manage traumatic events with frightened children may develop from early and continued reliance on imaginary playmates (Putnam, 1985). While it is developmentally common for young children to have imaginary playmates, there are some distinguishing differences between imaginary playmates and formation of self states. Dissociative children's tenacious assertion that the dissociative states are real is one of the prominent responses I and others (Frost, et al 1996) have observed in young traumatized children who exhibit dissociative states, contrary to children who engage in fantasy play. For example, when I query the latter group in play therapy whether their expressed self-ascribed name is "real," they will look at me in a perplexed way, and respond, "No, silly. I'm just pretending." They will resume their fantasy play *without any disturbance of affect*. However, young children with DID are more likely to argue and persist that their self states are real and are separate from themselves. They become very impatient when attempts are made to explain otherwise and are insistent about their separateness. In addition, they will exhibit other dissociative symptoms described above providing a composite picture meeting the criteria for a dissociative disorder.

Another challenge in accurate diagnosis of this age group is that their dissociation can easily be misinterpreted and camouflaged due to linguistic deficits (Chicchetti & Beeghly, 1987; Beeghly & Cicchetti, 1994; Yehuda, 2005), and as yet undeveloped cognition, which may, in turn, have been impaired by maltreatment and a chaotic environment. These children's troubling presentation can be easily misconstrued and misdiagnosed as a pervasive developmental disorder, missing the significance of their dissociative behaviors and perhaps yet undiscovered trauma.

Complicating environmental factors can also hinder a correct diagnosis. It is a taxing process to gather a comprehensive child developmental history from caretakers – biological, foster or adoptive– who may not be attuned to the child, may misinter-

pret the meaning of their child's disturbed behaviors, or do not have such history. Worst of all, caretakers may be either directly or covertly involved in their child's maltreatment. The clinician needs to carefully investigate this possibility while simultaneously evaluating the following: family dynamics, quality of the family relationships (particularly parental attachment history), parents' relationship with their child, and environmental influences, i.e. domestic violence, mental illness, substance abuse, and caretaker's overinvestment of the child's dissociative responses that maintain the child's dissociation (Peters, et al 1998). Assessing the quality of family relationships is particularly significant because these relationships may contribute to the formation of disorganized attachment with the child, which may predispose the child to dissociate.

This evaluation process must also be accomplished under the umbrella of an empathetic approach so as not to malign the child's caregivers. Not a simple task! However, the use of the Child Dissociative Checklist (Putnam, et al 1993) can be very helpful to the parents and clinician in detecting dissociation with young children and a springboard for more thorough discussion of dissociative indicators. Educating the parents about dissociation is paramount to helping them persevere in a loving and accepting manner with their child (Waters, 1996), while also being empathetic to the challenges of raising such a child. This approach needs to be accompanied with compassion for the child's struggles.

Diagnosing preschool dissociative children is critical to sparing them a lifetime of pain, agony and confusion. Like damaged tender spring shoots that regain their strength and vitality with proper care, so can young dissociative children demonstrate amazing resilience. They can recover from traumatic experiences and regain their spark. With early detection, a safe and nurturing environment, and appropriate intervention, they can go on to bloom and flourish into fulfilling adulthood.

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