

Post-Traumatic Syndromes in Childhood and Adolescence

A Handbook of Research and Practice

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Chapter Eight

Dissociation in Traumatized Children and Adolescents

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Introduction

This chapter explores childhood dissociation, its use as a defensive response during child abuse, and its ensuing dissociative psychopathology. For the purposes of this chapter dissociation is assumed to be a normal childhood ability that develops as a psychological defense mechanism in the face of extreme or prolonged and inescapable physical, sexual, and emotional traumas. It works as a shield against the conscious experience of overwhelming stress by producing psychological and/or physical analgesia, emotional calming, and a breakdown of the normally integrated experiential components of behavior, affect, sensation, knowledge, and identity.

Following Spiegel and Cardeña (1991), I refer to dissociation “as a structured separation of mental processes (e.g., thoughts, emotions, cognition, memory, and identity) that are ordinarily integrated” (p. 367).

Normal childhood dissociation

Childhood dissociation is a normal phenomenon familiar to many parents. Children often show their ability to dissociate when they lose themselves in daydreaming, when they talk to imaginary friends or immerse themselves in prolonged fantasy games. The plasticity of the child’s reality is often a source of joy and amusement to both the youngsters and their families. Children bask in their imaginativeness when they make believe they are different. For example, they can pretend in role-play that they are Daddy, a doctor or a

princess. They can also "make" others and their environment change, for example, by imagining that their dolls and toys can talk or by the pretense that their friends are soldiers, shop attendants or hairdressers. Children can also get completely absorbed in their activities and become totally oblivious to their surroundings. The "make-believe world" children develop does not interfere with their reality testing. Healthy, playful childhood dissociation is marked by an appreciation of the difference between what fantasy is and what is real.

Children, like adults, can find themselves reading entire paragraphs without knowing what they have read because their minds have gone somewhere else. In its common form, normal dissociation includes staring while daydreaming, *zoning out* or doing things on *autopilot*, for example, when children may think about what they are going to do after class and miss something important said by the teacher. This form of dissociation occurs more often during boredom or monotonous activities. In this sense, dissociation offers an ability to do more than one thing at a time. While the child may be half-hearing what is happening in a boring class, his or her mind can wander off somewhere else. These instances of normal dissociation can also be observed in nature where, for example, mammal cubs can be seen playfully engaged in "make-believe" hunting or mating games, completely unaware of a nearby predator their mother is attentively monitoring. These instances of normal dissociation do not interfere with the child's development and social and academic progress.

Almost all children also daydream, a form of normal imaginary dissociation from reality. In daydreams, the child forms a mental image of a past experience, often a pleasant one, or of a situation that he or she has never actually experienced. Daydreams may be triggered by a situation, a memory or a sensory input (sight, taste, smell, sound, touch). The daydreaming child may use these mental pictures to satisfy wishes, to escape from a boring reality temporarily or to overcome a frustrating situation. Children often talk or act out the scenario envisioned during their daydreams. Many young children include an imaginary playmate in the mental images of daydreaming. Toward preadolescence an internalizing process of daydreaming begins. Older children create private mental images and are less likely to talk or physically participate in their daydreams (Gold & Henderson, 1990).

Children, like adults, can also distract themselves and block out an unpleasant thought or feeling without harming their overall functioning. In this sense, normal dissociation works very much like instances in medical hypnosis, when children are instructed to focus their attention on distracting images or activities during potentially painful procedures to alleviate their discomfort.

Normal childhood dissociative abilities peak during latency years and decline during adolescence. When childhood trauma intersects this developmental window of proneness to normal dissociation, some children are thought to harness their innate normal abilities to generate effective ways of coping.

Dissociation as an adaptive response during childhood trauma

The first to recognize the association between pathological dissociation and trauma was Pierre Janet (1859–1947). In his first book on psychology, *L'Automatisme psychologique* (Psychological Automatism), Janet described his dissociation theory and a variety of psychological phenomena observed in hysteria, hypnosis, and possession states (Janet, 1889). Currently, two major theories describe best the pathogenesis of adaptive childhood dissociation in the face of child abuse: betrayal trauma theory (Freyd, 1996) and the Discrete Behavioral States model (Putnam, 1997).

Betrayal trauma theory suggests that violence perpetrated by a care-giving individual on whom the child is dependent will be associated with psychological dysfunctions manifested in memory or dissociation aimed at aiding the child in maintaining the essential attachment, despite its abusive nature. This theory has been supported by several studies demonstrating that childhood abuse by family members is related to elevated dissociative symptoms, while stranger abuse is not (e.g., Chu & Dill, 1990; DePrince, 2005; Plattner, Silvermann, & Redlich, 2003). The Discrete Behavioral States model posits that pathological dissociation stems from the child's inability to learn to integrate mental states. Putnam (1997) reminds us that in normal development, parents are instrumental in teaching infants to move smoothly between emotional states, for example, when children are shown ways to calm down and shift from a distressed to a neutral state. Infants communicate their needs mainly through alterations of behavioral states. For instance, crying is a common behavioral state infants enter to signal distress, motivating their parents to alleviate the distress by providing a need, by soothing or distracting. Maltreating parents are less attentive to their children's needs and therefore are less likely to offer emotional regulation and to model it. In response to punitive and harsh exploitative parenting, traumatized children compensate for their deficient self-modulating capacities by phobic avoidance, suppression of intrusive affects and images, and, finally, the disavowal and encapsulation of trauma-induced behavioral states – a process that can result in the pathological dissociation of trauma-induced mental states from normal conscious awareness.

The descriptor *pathological* is added to the term *dissociation* to describe dissociation that was first employed as a helpful reaction retrieved from the child's normal repertoire of behaviors and that was effective in regulating caretaker betrayal and inescapable harsh treatment. This defensive reaction evolves into a disorder when it becomes automated and develops into the main defense against all stressors. The psychopathologization of normal defensive dissociation encompasses several processes, among them: defensive automated behavior, compartmentalization of threatening mental materials, and the estrangement from the suffering self.

The pathologization of adaptive dissociation during child abuse

Compartmentalization

This form of dissociation can be described as a separation of discrete experiences and memories to the extent that they are not integrated in one's knowledge. Compartmentalized memory is a familiar occurrence to many of us who seem unable to recall information stored in a particular context if it is not retrieved in the same context. For example, one may decide while cooking to check a particular issue on the Internet, yet at their desk, they are unable to recall what was it that they wanted to do and only remember it when they return to check the cooking food in the kitchen. This form of dissociation is also known as state-dependent memory. The capacity to store psychological records of horrific experiences in "mental files" that are normally inaccessible to conscious awareness can allow children to avoid irresolvable cognitive dissonances and conflicts associated with bad experiences caused by beloved caretakers. Compartmentalized experiences often behave like classically (Pavlovian) conditioned stimuli (e.g., salivation in Pavlov's dogs) that are elicited following later exposure to the conditioned stimulus (e.g., the bell in Pavlov's experiment). Following is an illustrative example:

Rose, was only six years old when her sadistic father used to take her to the home's basement demanding that she role-play with him a series of ritualized acts in which he played a Nazi concentration camp guard and she was coerced into role-playing his inmate sex-slave. Rose had never heard of the term *Nazi* before. Although, she had developed amnesia for the complex exploitative rituals, she had always wondered about the sexual sensations she would experience later in life when exposed to information on concentration camps. The connection was only uncovered in therapy, 25 years following the abuse.

Compartmentalized memories often contain unprocessed, raw experiences that can present as disorienting flashbacks and reenactments.

Automatization

Highway hypnosis is a common example of the mind's capability of employing more than one stream of consciousness during routine or repetitive tasks. This withdrawal of attention from routine tasks does not diminish from quality performance of automated tasks because meta-cognitive monitoring processes usually switch awareness back to the task when deviation from safe or adequate

performance is risked. An extreme example of an automated behavior is dissociated automatism. The condition, often involving complex behaviors, has been observed under stressful conditions among individuals later assessed to display post-traumatic and dissociative disorders (Erdreich, 1994). The normal capacity to engage in behavior that is outside conscious awareness is probably quite adaptive in circumstances where children must perform complex behaviors when traumatized. For example:

Joan was four years old when her older brother begun teaching her *games* that involved nudity and touching. As the exploitation deteriorated, the brother introduced several habits including asking Joan to fetch a towel and Vaseline from the bathroom and to prepare the bed for her abuse. Joan had learned to switch off emotionally as soon as her brother called her into his room. Although her behaviors were completely compliant with her brother's expectations, she used to switch off her conscious awareness and go into her fantasy life while cooperating with her brother.

In this case the child was forced to perform a series of complex acts that were extremely traumatic. To survive and to also maintain her attachment to her brother, Joan learned to perform the requested behaviors well. However, to maintain sanity, she also had maintained unawareness of her actions. Dissociated automatism permitted these contradictory needs to be met simultaneously. I have encountered similar patterns of behavior among mental health workers acting as first-responders during terror attacks and shelling of civilian targets. Some of these professionals reported that under horrific circumstances of involving the need to manage the sounds, sights, and smells of injury and death they reverted to automatic, emotionless behaviors and, later, memory problems associated with these instances (Somer et al., 2004).

Depersonalization

Normal depersonalization may occur in fantasy child play when youngsters embellish reality or mold it for a better fit with emotional or creative play needs. This phenomenon is probably related to commonly familiar daydreaming. In his seminal book *Daydreaming*, Singer (1966) reported that 96% of presumably normal, fairly well-educated American adults engaged in some form of daydreaming daily. This mental activity was reported to occur chiefly when one is alone (e.g., in bed before sleep) and was said to focus principally on planning for future actions and reviewing interpersonal contacts. There has been a fruitful effort to quantify the traits associated with daydreaming. In the context of a study of excellent hypnotic subjects, Wilson and Barber (1981, 1983) serendipitously discovered a group of avid daydreamers later characterized

as "fantasy-prone personalities." These individuals were said to share the tendency to "live much of the time in a world of their own making – in a world of imagery, imagination, and fantasy" (Wilson & Barber, 1981, p. 31). Extensive or maladaptive daydreaming might be related to childhood emotional neglect or abuse that motivates victims to divorce from the threatening world and from their material entity (Somer, 2002). Depersonalization may represent a coalescence of imagination-based coping mechanisms to escape from aversive early life circumstances into a stable personality style marked by flight into fantasy and high psychological absorption. Following is a clinical example:

His school counselor referred Dan, an 11-year-old boy, for evaluation because of poor scholastic performance. The boy was described as inattentive and as "spacing out" extensively. A social services report indicated that Dan has been exposed to violent inter-parental conflicts that often involved blaming the child for the couple's misfortunes. Dan described a rich inner world in which he preferred to live. In it he was older and his family was harmonious and loving. Dan had spent all his free time fantasizing daily life in his alternate family. Often he would slip into comforting daydreaming during boring or stressful times.

This child used his normal imagination capacities to alter inescapable, harsh living conditions and to modify an emotionally harmful reality. Using his normal mental resources, he changed his helpless experience of dejection into one of control and emotional soothing. However, the relief experienced by his resourcefulness reinforced his motivation to elaborate his alternate imaginary life at the expense of engaging in academic and social life in his real world.

From ego states to identity confusion/alteration

According to Watkins and Watkins (1996), human personality develops through two basic processes, namely differentiation and integration. These processes operate both concurrently and intermittently. Through integration a child learns to put together concepts such as dog, mouse, cat, rabbit, and horse and therefore build units that are more complex called "animals." By differentiation, the child separates general concepts into more specific meanings, such as learning to distinguish between a mouse and a dog (Watkins & Watkins, 1993). Therefore, the child, by refining these concepts, develops more adaptive control of the environment. As integration may be considered a "putting together" process, differentiation may be called a "separating" process. Through putting together and separating human behavior, an experience evolves. Normal differentiation permits individuals to display one set of experiences and behaviors at a party and another at the office. Differentiation is adaptive, and some separation

of personality segments should make for better personality functioning. For example, a girl could display docile, nurturance-seeking behavior when visiting her grandmother but show independence and self-assurance at school. This is an example of adaptive differentiation of a personality into distinct yet integrated ego-states. Watkins and Watkins (1990) expanded their use of the term *dissociation* and defined the normal separating or differentiating process as dissociation. Many of the major theorists of personality have also proposed that the mind is made up of many subelves. For example, Berne (1961) talked of ego states, Jung (Proff, 1973) of complexes, and Angyal (1965) of subsystems.

An important characteristic of an ego state is that it was often developed to enhance the child's ability to adapt and cope with a specific problem or situation. Thus, one ego state may have taken over the overt, executive position when dealing with parents, another on the playground, and a different one during athletic contests. During child abuse, the specific situation is usually intolerable and inescapable. Ego states are often formed to help the child in coping with a variety of challenges. One ego state can help protect the primary alter from physical pain, another specializes in containing fear, a third one might learn to contain the sexual feelings. This process of differentiation can make it easier for the host personality to deal with the perpetrator during the abuse and after it, while carrying on with normal life in the family, with friends, and at school.

Stephanie was four years old when her alcoholic, neglectful, single mother begun abusing her physically as punishment for being untidy or for crying and expressing emotional needs. In an attempt to internalize the mother's orders, she would rehearse the commands and reprimands to the extent that her mother's messages were well assimilated into a distinct *Maternal Introject Ego State* that had echoed the mother's words and criticisms, internally. Since tears, crying, and clinging were prohibited, Stephanie had to learn to repress and disown her pain. Her mode of adaptation was the development of a *Frightened Child Ego State*, which had cried inside only. As she grew older, Stephanie had identified some new feelings associated with her need to resist her mother's hurtful behavior. Because expressing anger toward her only parent was too risky, Stephanie learned to contain her livid and rebellious feelings into an *Angry/Defiant Child Ego State* that had emerged exclusively at school.

This example illustrates the adaptive nature of normal personality differentiation in the face of overpowering childhood experiences. The *Maternal Introject Ego State* had effectively recorded the mother's demands and reminded the child continuously what expected behaviors are helpful in evading punishment. The *Frightened Child Ego State* had been adaptive in its isolation of the victim's overt neediness to allow safer internal ventilation of emotional pain.

The *Angry/Defiant Child Ego State* helped in containing forbidden affect at home, yet provided an outlet for more empowering experiences under less toxic circumstances. Under chronic abusive conditions ego states can develop more opaque boundaries and greater autonomy and investment in separateness. These psychological elaborations can be at odds with the initial adaptive function of the ego states, for instance, *Maternal Introject Ego States* could develop into internal persecutor ego states and the normal ego state differentiation may well evolve into a pathological form of dissociation, for example, Dissociative Identity Disorder (DID).

Childhood dissociative disorders

It is generally acknowledged that severe dissociative psychopathology originates in childhood. For example, in a review of 100 adult clients diagnosed with DID (then termed Multiple Personality Disorder, MPD), 89% of the clients indicated their first alter personality appeared prior to age 12 (Putnam et al., 1986). Early identification and treatment of childhood dissociative disorders may prevent the development of more complicated and broader psychopathology in adulthood. Waters and Silberg (1996a) have suggested that the treatment of youngsters diagnosed with dissociative disorders may be less complex and of shorter duration than the treatment of the adult client. It is, therefore, vital that pediatric mental health professionals familiarize themselves with assessment and treatment skills that would promise effective help for abused children.

Impediments to the identification of childhood dissociative disorders

Because dissociative disorders have been widely associated with the more severe and controversial forms of dissociative psychopathology, unless bizarre behavior is displayed, most clinicians tend to discount the likelihood of dissociative disorders presenting in children. As noted earlier, many forms of dissociation are normal among children. This may lead even perceptive clinicians to inhibit their identification of disordered patterns. Since dissociative experiences are often ego-syntonic among youngsters, many children do not realize that coping patterns with stress are unusual and would, therefore, tend not to complain about their dissociative tendencies. Finally, childhood dissociative symptoms patterns are often identified as disorders that are more common among children. Among the most common diagnoses provided to children who have been later recognized as suffering from dissociative psychopathology are attention deficit/hyperactivity disorder, mood disorder, and conduct disorder.

Symptom classification

The *Diagnostic and Statistical Manual for Mental Disorders-Revised (DSM-IV-TR, APA, 2000)* classifies the dissociative disorders into Dissociative Amnesia,

Dissociative Fugue (with a primary disturbance in memory for both with an additional feature for Dissociative Fugue of travel to a new location and the assumption of a new identity), Depersonalization Disorder (with a primary disturbance of detachment from one's thoughts or body), Dissociative Identity Disorder (DID), and Dissociative Disorder Not Otherwise Specified (DDNOS) (with a primary disturbance in identity). Dell (2001) described several disadvantages of the *DSM-IV-TR* criteria for dissociative disorders. He argued that the *DSM-IV-TR* criteria for DID: are out of step with the state-of-the-art of psychiatric classification; have poor content validity; throw away important information; have poor reliability; and cause frequent misdiagnoses. A set of core dissociative symptoms has been identified as essential elements of the broader spectrum of dissociative psychopathology.

While a complete examination of the entire spectrum of childhood dissociative symptomatology and its treatment is beyond the scope of this chapter, a more focused account of common childhood dissociative symptoms might be suitable. Focusing on childhood core symptoms and processes is warranted because the characteristics of dissociation found in children fall even less into the DSM diagnostic categories than do those of adults (Silberg, 2000). Putnam (1997) offered a more phenomenological description of dissociation. He divided the primary dissociative symptom clusters into (1) amnesia and memory symptoms (e.g., fragmentary autobiographical recall, amnesia and time loss, perplexing fluctuations in skills, fugue states), and (2) dissociative process symptoms (e.g., depersonalization, derealization, passive influence/interference experiences, dissociative auditory hallucinations, dissociative "thought disorder," alter personality states, and switching behaviors).

Memory symptoms

Fragmentary autobiographical recall

Most children form their first enduring childhood memories after age three. The infant's mind is simply not mature enough to create long-lasting autobiographical memories. In particular, it is not until the age of three or four that toddlers have a mature hippocampus and prefrontal cortex. These regions of the brain are known to be associated with the formation of autobiographical memories of the type notably missing from adult recollection of early childhood (Newcombe et al., 2000). The incomplete development of language in young children may be another cause of childhood amnesia in that infants do not have the language capacity to encode autobiographical memories in a manner that their language-based adult selves can interpret correctly. Autobiographical memory gaps observed in dissociative youngsters often relate to age-demarcated or other specific patterns of forgetting. For example: localized amnesia, selective amnesia, and systematized amnesia (Van der Hart & Brom, 2000). Localized amnesia is a gap in memory in which the child fails to recall

events that occurred during a circumscribed period of time. Following is an illustration previously reported in an article on the treatment of a Holocaust child survivor (Somer, 1994):

Bronya was a 58-year-old woman, born in Poland, who survived the Holocaust, amongst others, and a year-long internment in Auschwitz. She was 11 years old when she saw the American liberators enter the gates of Auschwitz. My diagnostic impression was one of Post-Traumatic Stress Disorder, chronic, with dissociative features and psychosomatic correlates. The patient was amnesic to almost the entire duration of her imprisonment in Auschwitz. Fragmentary recall was devoid of any affect. The patient had only scarce memories of the years prior to her internment in the death camp. She felt as if her life began only following her liberation.

Selective amnesia is a condition in which the child can recall some, but not all, of the events during a circumscribed period of time, for example, an abused girl may recall only some parts of a series of violent, sexually abusive incidents, but not the actual penetration. Systematized amnesia occurs in cases where the child loses memory for certain categories of information, such as all memories relating to a particular person, or certain activities with that person (e.g., a child can remember her father used to take her on outings every Saturday between ages five and 10, but have no recollection on what transpired on these occasions).

Amnesias and time loss

Children often notice disruptions in their sense of time when they repeatedly experience "waking up" in the middle of an activity with no recollection of when or why they started that behavior or when they notice time (sometimes hours) has gone by without them knowing what they did during the lost time. These children can be observed to be "spacing out" or staring motionlessly for prolonged periods of time. Some dissociative children are less able to recall detailed information related to specific circumstances. For example, memory regarding time they spent with an uncle is always sketchy and vague. Another instance of lost time relates to disremembered behavior:

Carolyn, a timid 10-year-old girl, had been getting herself in trouble during the two months preceding her referral for evaluation. Her teachers had become perplexed by the emergence of complaints by schoolmates concerning behaviors that were out of character for Carolyn: pushing and hitting younger girls. She has been observed pushing these girls from

behind, causing them bleeding injuries. Sobbing and appearing offended and baffled, Carolyn denied that she would ever do anything of the sort. The teacher reprimanded the girl for her blatant lying.

Disremembered behaviors could also manifest themselves in the finding of unexpected possessions that the child does not remember receiving or acquiring, or when new artwork is found that is not in line with the typical style or skill of the child or which the child denies doing.

Puzzling variations in skills

Another common form of dissociative memory dysfunction among children is manifested in inexplicable changes in ability and recall of acquired knowledge. Children showing this type of behavior can be suspected of suffering from motivational problems, learning disabilities or plainly lying. Following is a typical example:

Sharon, a 10-year-old bright, female fourth-grader, long known to the local social welfare services as a neglected child from a poor, single-parent family, had been observed on occasions to scavenge school trash cans for food. Her teacher reported to the school psychologist that the girl would suddenly appear to be unable to read or perform simple math, tasks that she had mastered well by second grade. Sharon attempted to compensate for her sudden loss of ability by refusing to perform or by claiming she was sick to her stomach. Sharon confided to the school psychologist that she actually forgot, at times, how to read or do simple calculations and that she felt shamed by what she termed "stupidness attacks."

Putnam (1997) states that seemingly random fluctuations in knowledge and skills can create suspicion about the plausibility of such skills disappearing suddenly and may contribute to a false impression that the child is lying.

Fugue states

During a fugue, the child may appear normal and attract no attention. The condition is suspected when a child seems confused over his identity or puzzled about his past. Dissociative fugue involves episodes of amnesia in which the inability to recall some or all of one's past and either the loss of one's identity or the formation of a new identity occur with sudden, unexpected, purposeful travel away from home. The length of a fugue may range from hours to weeks, but it is usually of short duration, particularly among children.

Yossi, a 14-year-old youngster, was stopped by a military patrol as he was wandering dangerously close to a minefield near the Israeli-Syrian border. The youngster reacted with belligerence and had to be restrained for questioning. Initially, the boy was unable to provide coherent responses as to his identity and home address. Not more than 30 minutes into the interrogation, Yossi suddenly froze and his facial expression changed from angry and defiant to shocked and frightened. He began weeping, claiming he had no recollection of how he got to the border. The last thing he remembered was being scolded at school for not having prepared his homework properly.

His maternal grandmother had raised Yossi after his violent abusive father murdered his mother. A later psychological evaluation determined a diagnosis of DID. Yossi's example is not atypical in that fugue states often reflect switches in executive control that occur when an alternate personality takes over in DID.

Dissociative process symptoms

Depersonalization and derealization

This process involves an *alteration* in the child's perception or experience of the self so that she or he feels *detached* from, and as if the child is an *outside* observer of, his or her body. Dissociative youngsters may report that they feel or watch themselves act, while having no control over what transpires. Derealization, an alteration in the perception or experience of the external world so that it seems strange or unreal, frequently accompanies depersonalization symptoms. These symptoms can distort the child's visual perception (e.g., seeing the world in faded colors, dimly lit, through a bubble or fog, hearing sounds as muffled, etc.), but they do not impair sight or reality testing. Nevertheless, many youngsters who suffer from depersonalization also experience a numbing sense of estrangement and detachment from their emotions and feelings that in itself can be distressful and conducive to depression.

Passive influence/interference experiences

Passive influence experiences, also known as Schneiderian first-rank symptoms, have long been considered accurate markers for schizophrenia. However, these symptoms are now regarded as core characteristics of severe dissociative psychopathology (Dell, 2001); they are more common in severe dissociative disorders and are not a useful indicator of psychosis when a differential diagnosis is conducted. Passive influence/interference symptoms comprise feelings,

impulse actions or thoughts that feel to the child as if they are imposed from an external source, including the delusion that thoughts are being inserted into the mind or *taken out* of the mind by someone else. They are also called *made* feelings, *made* impulses, *made* actions. Children who experience these core dissociative symptoms may also report thought blocking. The child may experience a break in the flow of thoughts, believing that the missing thoughts have been withdrawn from the mind by some unknown agency. However, unlike schizophrenics, dissociative individuals often claim that the experience feels like an internal struggle for control.

Dissociative auditory hallucinations

Hearing voices is the second common source for misdiagnosis of dissociative children. However, auditory hallucinations in dissociative pathology usually refer to a traumatic scenario, an inner conversation among personality states (to be described later) or alters' attempts to influence the identity in apparent executive control. They are usually coherent. When fragmentary, it is usually because they have not been heard completely. Auditory hallucinations of dissociative disorder patients are heard as emanating from inside the head in over 80% of cases. For schizophrenics, over 80% are heard as emanating from outside of the head (Kluft, 2003). Many internal voices heard by dissociative children are internal arguments or comments (often pejorative) on the child's behavior, but they can also be weeping voices or voices offering soothing solace. The voices often are consistent in their style, tone, gender, age, and internal role, and should be considered as powerful markers for the existence of distinct personality states (or alters), indicators of a DID. Auditory hallucinations in DID usually refer to a traumatic scenario.

Dissociative "thought disorder"

Incoherence and true loosening of associations do not characterize thought disorder among dissociative children. Dissociative youngsters may report the presence of inner voices and express vocally inner conversations among alters. When their speech sounds fragmentary, it is usually because alters may have not been heard completely. Harrow and Prosen (1978) discovered that many instances of thought disorder arose because the individual had "intermingled" associations from past events with the current context, but had failed to explain this to listeners. Dissociative thought disorder may occur if the child does not disclose the nature of his or her inner world or personal associations. The intrusion of past traumatic material may also be involved in this process. When a traumatized young person experiences a flashback, his or her *thought-disordered* speech might be appropriate to the reexperienced trauma but inappropriate in the present context.

Since some of the dissociative process symptoms can be confused with psychotic signs, differential diagnosis should also consider the following additional points:

1. Unlike schizophrenia, dissociative disorders present no negative symptoms.
2. Deteriorated behavior is uncommon in dissociative disorders unless there has been prolonged hospitalization.
3. Hypnotizability is usually high in dissociative disorders and low in schizophrenia.
4. Suggestive techniques often can modify *psychotic* symptoms.
5. Disorganized behavior and thought in dissociative disorders are mostly the result of switching behaviors and processes between alter personality states.
6. Almost all children and adolescents with dissociative disorders have been severely traumatized and probably also suffer from PTSD. Most schizophrenic kids do not.

Alter personality states

The *DSM-IV-TR* (APA, 2000) uses the term "alter" to describe the distinct identities or personality states that the individual with DID experiences. To be classified as a "personality state," the following conditions must be met: a consistent and ongoing set of response patterns to given stimuli; a significant confluent history; a range of emotions available (anger, sadness, joy, and so on); a range of intensity of affect for each emotion (for example, anger, ranging from neutrality to frustration and irritation to anger and rage). This is the most dramatized aspect of dissociative disorders. The skepticism this clinical phenomenon elicited in the mental health field was, probably, a major motivation behind the name change from Multiple Personality Disorder (MPD) to Dissociative Identity Disorder (DID). Persons with DID usually have one personality that controls the body and its behavior. Professionals refer to this alter as the "host." This is generally not the person's original personality or birth personality. The host is often initially unaware of the other identities and typically loses time when they appear. The host is the identity that most often presents itself in treatment, usually after developing symptoms, such as school performance, attention deficit problems or depression. The number of alters in any given case can vary widely. Although poly-fragmented cases with dozens of alter personalities have been reported in survivors of sadistic abuse, the mode is three and the median typically eight to 10 (Putnam, 1997). Patients vary with regard to their alters' awareness of one another. Some alters may acknowledge the existence of others, different alters can be completely oblivious to the existence of an internal structural fragmentation. Alters are often of different genders, i.e., boys can have female alters and girls can have male. Other types of alters include children, protectors, and persecutors. Youngsters

who appear to assume whole new physical postures, voices, vocabularies, preferences, moods, knowledge, skills, or handwritings should be assessed for alter state personality activity, also known as *switching*.

Switching behaviors

Experts refer to the phase of transition between alters as a *switch*. While the appearance of switching may exist in rapid-cycling bipolar disorder and in panic attacks, they are central features in severe dissociative psychopathology. Specific circumstances or stressful situations may bring out particular identities. Some young patients may display erratic performance in school, in sports or in social circumstances caused by the emergence of alternate personalities during stressful situations. Each alternate identity takes control one at a time, denying control to the others. Conflict with regard to the executive control of the patient or with regard to participation in therapy is often an essential process. Switches may be manifested by a variety of signs with individual variations typical of each youngster. Examples of observable switching behaviors include: an eye-roll or rapid blinking, a sudden change in mannerism, an abrupt derailment of thought, an expression of puzzlement usually coupled with grounding behaviors (e.g., visual scanning of the office), a postural shift or a sudden change in voice pitch.

Treatment principles and phases

Based on Kluft (1993), Waters and Silberg (1996b) formulated principles that distinguish effective therapy with dissociative children and adolescents. Therapists are cautioned to remain alert to issues of ongoing safety and to employ sensitivity and wisdom when working with the potentially conflicting interests of families, police, and child protection services.

1. Although some professional contact outside therapy is sometimes needed (e.g., a house visit), therapists should maintain firm professional boundaries and avoid dual relationships with their youngster clients and their families.
2. The therapist must maintain a solid therapeutic bond not only with the child but equally importantly with the parents, who often are the gatekeepers of the therapy. If the family environment is judged to be inappropriate for the child, the therapist should work toward securing a safer setting (e.g., residential shelter or foster care).
3. The therapist should hold the youngster (all personality alters included) accountable for his or her behavior. Rules should be conveyed to "all inside" and denial of responsibility of actions performed outside consciousness should provide opportunities for enhancing internal communication and control.

4. Children cannot be expected to give up dissociative defenses as long as they continue to live in abusive circumstances. For treatment to be effective the child must be in a safe and preferably nurturing environment.
5. Dissociative minors in therapy are dependent on many adults within and outside the family. Effective treatment with youngsters must comprise a multidisciplinary team to address the many needs and issues involved with resolving the traumatic outcome in the life of the young patient.
6. Therapeutic goals should work toward developmentally appropriate behavior, activities, and skills, including participation in sports, clubs, youth movements (e.g., girl scouts), creative activities, and hobbies.

Trauma experts agree that, regardless of patient age, trauma work should follow a progression in a three-phase process. The first phase involves assessment, accurate identification of the child's unique symptom clusters, reassurance and education about the traumatic disorder and its treatment, and relationship-building with the child, family, and the professional team. The initial phase does not end before safety and stabilization in the child's life are achieved. The second treatment phase involves the development of a narrative of the traumatic events and processing of the harmful experiences. The third phase of therapy involves integration of the dissociated processes and personality structures, and the development of age-appropriate, healthy ways of coping.

Conclusion

Accurate identification, assessment and treatment of dissociative children and adolescents are not straightforward professional challenges. Firstly, children display a wide array of dissociative-like behaviors that are not necessarily pathological. Secondly, the very nature of many dissociative defenses is covert and often hidden from the untrained clinical observer. Thirdly, many dissociative symptoms mimic more familiar psychological disorders. Fourthly, some dissociative symptoms have been sensationalized and created grave skepticism in some professional circles regarding the validity of dissociative disorders as a whole, and also sadly, the veracity of the uncovered trauma memories themselves. Making a correct diagnosis of children and adolescents with dissociative disorders offers these suffering children the only hope for effective treatment. Proper identification and treatment of traumatized children are perhaps their only hope to move away from their painful past. The promise of healing and recovery from perpetual pain caused by child abuse and neglect is not only a satisfying act of professionalism, but also an expression of sublime justice for the young patient: extracting the child victim from the perpetual pain they were trapped in.

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