PRACTICE

THE DISSOCIATIVELY DISORDERED CHILD

—by Beverly James

Dissociative disorders, including multiple personality disorder, are frequently associated with chronic childhood abuse. Defensive dissociation keeps overwhelming emotions, thoughts, and sensations from conscious awareness, enabling youngsters in intolerable circumstances to function. Unfortunately, it may become so extreme that it defeats its own purpose and dramatically inhibits functioning and development.

Professionals working with abused children are in a unique position to identify these disorders and to intervene in time to prevent further development and entrenchment. Because we are still in the early phases of understanding dissociative phenomena, particularly in children, our theoretical formulations should be tentative and our clinical approach open and flexible. We should be alert to the possible presence of dissociative disorder, however, because dissociative disorders tend to intensify over time, rather than remain static or improve like many other disturbances. The more current knowledge we have about etiology, diagnosis, and treatment of these disorders, the more effective we will be in our work with abused children.

Etiology.

Dissociative disorders seem to be caused in part by extreme dysfunction in family relationships. Double bind communication, enmeshed family systems, and pseudomutuality, once considered part of the etiology of schizophrenia, may more properly be identified in the family dynamics of those who have multiple personality disorders (Spiegel, 1984). Hornstein (1989) notes that confusing, contradictory relationships within the family are often preserved in alter personalities' relationships with each other and in the child's relationship with the therapist. Hornstein identifies the following categories of dysfunctional behavior by caregivers of children with dissociative disorders:

Emotional fragility: The caregiver's mental disorders, substance addiction, personality disturbance, and suicidal behaviors demand that the child assume responsibility for the caregiver's physical and emotional care. Instead of being reliably nurtured, the child becomes highly attuned to the caregiver's needs, both to prevent her or his own abuse and to safeguard the parent's life and health.

Unpredictable responses: Caregivers may respond to the same behavior with lavish rewards one day and savage punishments the next, leaving the child with no idea how to behave. The parent alternately rejects the child and fosters intense dependence.

Repetitive abuse and obliteration of boundaries: The caregiver's abuse of the child has a compulsive, sadistic quality. The caregiver overidentifies with the child, relentlessly projecting his or her emotions onto the child, failing to recognize the child's separate existence.

Malicious overinvolvement: The caregiver rigidly controls all aspects of the child's life, including affective expression. The caregiver may punish the child, for example, for spontaneously laughing or crying. These parents are anything but neglectful: they rigidly control the child's dress, actions, friendships, etc. Yet they often ignore the child's basic needs for nutrition, medical attention, and physical safety.

In addition, dissociative children may have been raised by caregivers who themselves suffer from multiple personality disorder. In such cases, children may learn their caregivers' dissociative behavior (Coons, 1985 Hornstein, 1989). Such learning may be facilitated by dissociative parents who label their children's normal behaviors as manifestations of different entities existing within the youngster. Some dissociative parents may have alters who are abusive to the child, or may confuse their child by switching to alters of various ages and sexes, each of whom relates differently to the child.

Diagnosis.

What do childhood dissociative disorders look like? Dissociative behaviors that are persistent and impair children's functioning include the following:

Involuntary detachment: entering into trance states in response to stressful stimuli.

Depersonalization: feeling detached from oneself, or unreal, alien, mechanical.

Repression: being unable to recall important events. The memory of a specific event may not be consciously available, while memories temporally surrounding the event are recollectable.

Psychogenic amnesia: being unable to recall important personal information, such as one's age, name, parents' names, etc.

Dissociative splitting: disowning experiences or behavior, attributing them to someone or something else "not me."

Incipient multiple personality disorder: the presence of a consistent, unintegrated personality fragment (person, animal, cartoon character, for example) that may or may not be consciously recognized. The fragment functions as a repository for unacceptable experiences but is not sufficiently developed to take full control.

Multiple personality disorder: perceiving oneself, or being perceived by others, as having two or more distinct and complex personalities. Behavior is determined by the personality that is dominant at the time.

Successful work with dissociative disorders begins with diagnosis. But accurate diagnosis is not easy. Caregivers often don't help. They may not recognize symptoms as unusual, and commonly do not report symptoms that may seem strange but are not troublesome. Caregivers who want to hide their own dysfunction or abuse generally won't report their children's symptoms no matter how glaring. In addition, children have difficulty describing their internal experiences even when they want to, and may not be willing to reveal or discuss a dissociated part until they believe it is safe to do so.

Clinical assessments often miss dissociative disorders for several reasons. For one, dissociative episodes are not always disordered states: many are benign and pass unremarkably. Further, a normal child's behavior and temporary response to extreme stress can mimic some symptoms of dissociative disorder. In addition, some symptoms of dissociative disorder can be seen in normal children and adolescents, and many of these symptoms occur as well in children with other problems. We may overlook symptoms of a dissociative process until the child relives a traumatizing event and responds by revealing another personality or fragment. Some children may not be diagnosed until they create a new identity to deal with a current problem.

Clinicians can, however, be on the lookout for a number of behaviors that are more specific to the dissociatively disordered child. Both Kluft and Putnam have generated predictor lists for childhood multiple personality (see both in Kluft, 1984). Behavioral checklists specifically designed to identify dissociative disorders in children have been developed by Fagan and McMahon (1984) and Dean (1989). Among the behaviors warranting attention are the following:

* spontaneous trance states, when the child "spaces out" or stares off into space;
* denial of behavior that has been observed by others;
* description of self as "unreal" or "an alien";
* feeling remote from the environment or that surroundings are altering;
* getting lost coming home from school or from a friend's house;

Continued on next page

JAMES *(Continued from page 8)*

* use of another name;
* claiming that she's not herself, or has a dual identity;
* reference to self as "we";
* change in ability to perform tasks;
* sudden changes in vision, handwriting, style of dress;
* auditory hallucinations;
* loss of time;
* drawing self as more than one person.

A diagnosis of dissociative disorder should be seriously considered if the child manifests several of these behaviors over a substantial period of time. Still, other possible explanations should be ruled out before a diagnosis is made. Competing explanations include the following:

* Allergic reactions to foods, plants, and other substances. Caregivers sometimes describe allergic children as suddenly changing behavior for no apparent reason. Allergic children may show significant changes in handwirting, attention span, and learning ability.

* Organic disorders related to stress whose symptoms include memory difficulties and clouding of consciousness.

* Drug use, which can cause dramatic behavioral changes, blackouts, and failure of recall. Clinicians working with children under medical care should consult with the supervising physician to learn of any drug use and possible side effects of any prescribed medications. Drug use may also be recreational, even in young children, or deliberately induced by ignorant or abusive parents or as part of a ritual.

* Other psychic problems that may involve attention deficit, conduct disorder,and eating disorder.

Treatment.

Treatment should begin as soon as possible after competing explanations are ruled out and a diagnosis of dissociative disorder is made with some confidence. Youngsters with dissociative disorders need specialized treatment interventions in addition to those regularly used to help abused and traumatized children (Kempe and Helfer, 1972, Pynoos and Eth, 1985, MacFarlane and Waterman, 1986; James, 1989).

A first step in beginning treatment is to assess the home situation for the presence of abuse. If abuse is incipient or ongoing, steps must be taken to ensure the child's safety. The initial assessment should also ascertain whether the child is a danger to herself or to others.

Ensuring the child's safety is not only a legal and moral imperative, but a prerequisite for effective therapy. The treatment goal is to help children feel safe enough to give up psychic separation. This task is sufficiently complex given these children's profound feelings of helplessness and distrust, and their great difficulty tolerating emotions: if they are not even physically safe, it is highly unlikely that treatment will be successful.

Ideally, a therapeutic alliance will be built with the child and her caregivers. Caregiver support can be a critical element of treatment, since caregivers can extend the treatment process into the home environment. If caregivers are highly dysfunctional, working with them may be impossible or impracticable. Whether or not caregivers can be part of the therapeutic alliance, treatment of the dissociative child should concern itself with the issues discussed below.

The child's dissociative experiences and disowned parts must be revealed in the treatment environment. Here they are safely contained while the therapist helps the child toward integration. Resistance comes, however, when the child lacks trust in the therapist's ability to accept her. Many dissociative children project their own self-blame, thinking that if the therapist knew everything—how she feels, what she did, exactly what happened—the therapist would blame her, dislike her, and turn away in disgust. Those thoughts, feelings, and memories the child experiences as too overwhelming or too dangerous to acknowledge are hidden behind amnestic or dissociative barriers.

A central therapeutic task, therefore, is to help the child feel safe. The best response is to begin where the child already feels safest, most often in areas of physical mastery and cognitive structuring. Through the use of music, movement,and physical games, the child can playfully be guided to increase her range of movement and to feel ownership of her body. Having the child show nonverbally what it may be like to be a lion, a tree, a robot, or a piece of bubble gum can be a helpful means to the same ends.

Cognitive structuring techniques can teach important information about feelings and can help the child learn to talk about feelings without being overwhelmed by them. The child and therapist together can name, sort, discuss, and explore the nature of emotions without the youngster experiencing them. The child can learn that one person can have several feelings concurrently, and that some of those feelings may conflict. She can come to understand that feelings and actions are not the same, and that her feelings or thoughts will not get her into trouble. As therapy proceeds, the clinician needs to begin to delineate the child's awareness of, understanding of, and attachment to dissociative behavior. Using the child's own terms for dissociation will help promote trust and mutual understanding. Therapy can proceed along these general lines:

1. Help the child delineate and identify feelings that all children have, as well as the feelings the child will acknowledge she has. Do the same with the feelings of the split-off "parts" which she may have identified. Then examine together how the split-off feelings differ from her owned feelings, and what would happen if she claimed them.

2. Discuss together the function of the split-off part, perhaps using simile or metaphor. Show acceptance of the child's dissociative behavior and enable her to own it by helping her understand its positive aspects. You might tell her, for example, that she has protected herself, and possibly others, in creative, inventive, courageous, and caring ways.

3. Establish the child's ownership of the split-off part and her power over the splitting process. Acceptance of the splitting will facilitate this step, as will gradual reference to the dissociative split as being her creation and part of her.

4. Thoroughly investigate the child's dissociative process, working as a co-detective with the child. Together, child and therapist can identify and monitor the conditions that trigger dissociative responses, and differentiate between the different responses. Take care during this process not to reinforce the mechanism further. Do not, for instance, question so closely that the child is called upon to elaborate a more complex identity or fragment than already exists.

5. Help the child examine the advantages and disadvantages of "going away." If she can be convinced that there are more disadvantages (which will depend in large part upon her being in fact sure of her physical and emotional safety), work can progress toward controlling and lessening defensive dissociative responses. Begin to present dissociation as a protection that was once needed but is now superfluous since the child is no longer at risk (if it's true that she isn't) and can cope in other ways when feeling really frightened. This idea may be experienced as criticism if presented before the child has other coping skills in place.

6. Ready the child to give up this obsolete coping mechanism. One way to do this is to have her recall and reexperience a time when she successfully coped with loss. For example, she probably gave up a baby bottle or a favorite blanket.

Quietly remind her that these things once provided comfort, as splitting does, but are no longer needed. Therapist and child together acknowledge that we do miss such things for awhile, but get over it.

7. As a joint effort, create a treatment plan aimed at gaining control of the behav-

Continued on next page

JAMES *(Continued from page 9)*

ior. Including her in the planning process helps her gain a much-needed sense of control. Therapist and child should concurrently work on ongoing conflicts, on alternative ways the child can cope, and on ways to change the environment so that the need for dissociative defense lessens.

The therapist will have to help caregivers, teachers, and others learn to accept dissociation without promoting it. The child's behaviors may make her the center of attention. Some who focus on her may do so out of curiosity or meanness, others to prove or disprove the diagnosis, others in a misguided attempt to cure the child by ridicule, harrassment, or shock. Adults in close contact with the child should be sufficiently familiar with the dissociative process and its appearances so that any fascination is defused. Remind them, for instance, that we all dissociate to some degree when watching a movie, or driving a long, straight, boring road, or listening to a symphony.

8. Integration (uniting of the split-off parts) is a long, slow process that can't be forced. It occurs with the reduction or resolution of conflicts and the learning of new coping skills. Although spontaneous integration may occur after a release of strong feelings related to traumatic events, it shouldn't be interpreted as a spontaneous cure: much conflictual material may still remain hidden. The therapist needs gradually and carefully to determine this possibility through discussion and directed play.

To be as helpful as possible, therapists should make sure to deal with the feelings of loss they may experience initially in relation to the process. Children, too, should be encouraged to talk about what integration will mean to them.

Integration will occur gradually as a result of the child's desire for normalcy, her participation in a healing environment, her freedom from abuse, and her evolution of new coping skills. Integration can be boosted and reinforced with visualization exercises. For example, have the child close her eyes and, through vivid imagery, bring together the separated parts of herself. Each part might be a color, which joins all the others to form the rainbow of self.

Continued support is necessary for some time, while the clinician helps the child solidify gains and supports her in using her new coping skills to negotiate the inevitable bumps along the developmental road.

The identification and treatment of dissociatively disordered children requires complex clinical skills, of which this article is only a brief overview. If we learn to recognize dissociative disorders promptly and to provide or secure appropriate treatment, however, we will be doing a great deal for the children we have chosen to serve.

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Beverly James, MSW, is director of the James Institute in Kona, Hawaii. She is author of Treating Traumatized Children *(Lexington Books, 1989), and co-author of* Treating Sexually Abused Children and their Families *(Consulting Psychologists Press, 1983).*

MYERS *(Continued from page 1)*

ing Argument to the Jury.

As mentioned above, many people think the goal of cross-examination is to get the expert to change her opinion or admit she might be completely wrong. Cross-examination sometimes has this dramatic effect, but not very often. The skillful cross-examiner knows she is not likely to get the expert to change her opinion, so she takes a more subtle approach.

The goal of cross-examination is usually not to score a direct hit on the expert, but to poke a few holes in her testimony. The cross-examiner hopes to raise questions about the expert's testimony—questions that are deliberately left unanswered until the cross-examiner's closing argument to the jury.

How does the cross-examiner raise doubts about the expert's testimony? By controlling the witness during cross-examination. Control of the witness is ac-

Continued on next page

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NEBRASKA LAW REVIEW (V. 68 [1989], NOS 1 & 2) ARTICLE, "EXPERT TESTIMONY IN CHILD SEXUAL ABUSE LITIGATION," by John E.B. Myers, JD; Jan Bays, MD, FAAP; Judith Becker, Ph.D.; Lucy Berliner, MSW; David L. Corwin, MD; and Karen Saywitz, Ph.D.

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CORRECTIONS

In the last issue of *The Advisor*, a typo was made at the end of Karen Saywitz's article, "Developmental considerations for forensic interviewing." On p. 15, the last sentence in the third paragraph from the end of the article should read, "Be sure to praise the children for their effort—working hard during the interview—*not* for the content of what they say." In the published version, "and" was substituted for that "*not*"—a critical difference. We're sorry for the mistake.

Also: *The Advisor*, V.3, n. 1 & 2, contained a bibliography of selected studies on "Incestuous Fathers and Families" by Linda Meyer Williams and David Finkelhor. Dr. Williams's name was inadvertently omitted from the byline. Additional information on the topic can be found in: L.M. Williams and D. Finkelhor (1990), "The characteristics of incestuous fathers: A review of recent studies," in Marshall, Laws, and Barbaree (eds.), *The Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (NY: Plenum).