

Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents¹

ISSD Task Force on Children and Adolescents, February, 2003²

The ISSD Task Force on Children and Adolescents is pleased to present the Guidelines for the Assessment and Treatment of Dissociative Symptoms in Children and Adolescents. In utilizing these Guidelines, you might keep the following principle in mind. According to the Criteria for Evaluating Treatment Guidelines of the American Psychological Association (2000), "Guidelines should avoid encouraging an overly mechanistic approach that could undermine the treatment relationship." We hope these Guidelines prove to be useful rather than prescriptive, and improve the care of children and adolescents with dissociative symptoms and disorders.

Joyanna Silberg, PhD, Task Force Chairperson

These Guidelines are dedicated to the memory of Elaine Davidson Nemzer, 1952-2000.

I. RELATIONSHIP TO ISSD ADULT GUIDELINES:

The ISSD Standards of Practice Committee issued "Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults" in 1994 and updated them in 1997. As these made no reference to children and adolescents, the ISSD Executive Council requested the Child and Adolescent Task Force to draft guidelines summarizing current clinical knowledge in the field applying directly to children and adolescents.

II. SCOPE OF DIAGNOSES ADDRESSED:

Although the ISSD Adult Guidelines are specifically directed to the treatment of Dissociative Identity Disorder (DID), dissociation in children may be seen as a malleable developmental phenomenon which may accompany a wide variety of childhood presentations. Symptoms of dissociation are seen in populations of children and adolescents with other disorders such as Post-Traumatic Stress Disorder (PTSD; Putnam, Hornstein & Peterson, 1996), Obsessive-Compulsive Disorder (OCD; Stien & Waters, 1999) and reactive attachment disorder, as well as in general populations of traumatized and hospitalized adolescents (Sanders & Giolas, 1991; Atlas, Weissman, & Leibowitz, 1997) and delinquent adolescents (Carrion & Steiner, 2000). These treatment principles, therefore, are intended for children and adolescents with diagnosed dissociative disorders, as well as for those with a wide variety of presentations accompanied by dissociative features. In other words, the Guidelines identify general principles

applicable to dissociative processes regardless of the child's³ presenting diagnosis.

Diagnosis itself seldom communicates much about the nature of the child and his or her world. These Guidelines are not intended to be a basis for differential diagnosis. While a dissociative diagnosis specifically geared to children has been proposed (Peterson, 1991), this has not been included in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, Text revision (DSM-IV-TR; American Psychiatric Association, 2000). Although even very young children appearing to meet the criteria for DID have been described (Riley & Mead, 1988; Putnam, 1997), the prevalence of DID in childhood is currently unknown. The diagnosis of Dissociative Disorder Not Otherwise Specified (DDNOS) is the most common in populations of dissociative children and adolescents (Putnam et al., 1996), even though no diagnostic criteria have been set for this diagnosis. While individual case studies of children with puzzling and atypical dissociative presentations described variously as Depersonalization Disorder (Allers, White & Mullis, 1997), Dissociative Amnesia or Dissociative Fugue (Coons, 1996; Keller & Shaywitz, 1986), and DID (Jacobsen, 1995) continue to be published in peer-reviewed journals, there is still no real consensus about the typical case and thus no consensus about diagnostic criteria. For this reason, in these Guidelines the perspective on assessment and treatment is symptom-based.

III. INTRODUCTION:

These Guidelines are derived from the published literature, material from conferences, and the clinical experience of members of the ISSD Child and Adolescent Task Force. As this field is in an early developmental stage, these Guidelines are to be viewed as preliminary. As the field develops, they will be modified to incorporate new research into diagnosis and treatment. In fact, the literature reviewed here, spanning over 16 years of reporting on dissociative phenomena in children, already shows shifts in emphasis and recommendations over time (Silberg, 2000). Despite the changing and provisional nature of our knowledge in this area, it is still important to have some guidelines in approaching dissociative symptomatology for the following reasons:

1. Treatment strategies aimed at increasing integration and re-

³ The word child is generally used in these guidelines to mean both children and adolescents through high school age.

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ducing dissociation can be highly effective in treating some of the most seriously impaired child victims of maltreatment who are engaged in disruptive and self-destructive behavior.

2. Information on the treatment of dissociation was not available when most clinicians did their training, and it is important to organize clinical information to help familiarize clinicians with current treatment approaches.
3. Without careful consideration of developmental issues, the simplistic application of treatment approaches for adult dissociation to children may be potentially dangerous to children.

For these reasons, these Guidelines are presented for the benefit of the ISSD membership and the clinical community at large. It is our hope that research will continue to amend and refine these Guidelines, and that their presentation will stimulate discussion, debate and further analysis that will enrich the field as a whole. These guidelines must be used in conjunction with all ethical codes, health codes, laws or professional regulations which govern the individual's discipline or place of practice.

IV. QUALIFICATIONS OF CHILD AND ADOLESCENT PRACTITIONERS

At this point in the development of this field, information about child and adolescent dissociation is still evolving. A good safeguard for doing "No harm" is a solid grounding in child development. Clinicians who treat dissociative children should have training in child therapy and child development through accredited programs in their respective disciplines and be familiar with a variety of treatment approaches for traumatized children (Cohen & Mannarino, 1998b; Deblinger & Heflin, 1996; Donovan & McIntyre, 1990; Friedrich, 1996; Gil, 1996; Heineman, 1998; James, 1989, 1994; Myers, Berliner, Briere, Hendrix, Jenny, & Reid, 2002; Pearce & Pezzot-Pearce, 1997; Prior, 1996; Terr, 1991; Tinker & Wilson, 1999; Wieland, 1997, 1998.) In addition, it is recommended that clinicians treating children with dissociative disorders participate in continuing education conferences, develop collegial relationships such as study groups or peer supervision, and stay current in the literature. As some of these children have suffered some of the most severe forms of maltreatment, collegial support for the therapist is particularly important to avoid secondary PTSD and burnout. It is important to understand the subtle countertransference issues that affect therapists who work with traumatized clients (Dalenberg, 2000).

As the literature on the treatment of dissociation in children has come from a variety of treatment orientations, the treatment of dissociative processes in children does not require allegiance to any one particular treatment model. Readers of these Guidelines are encouraged to adapt these ideas into the frameworks with which they are most comfortable. The most successful treatment approach to an individual case is often the most eclectic, with the therapist showing flexibility and creativity in the utilization of a wide variety of available techniques. This is well demonstrated by Cagiada, Camaido & Pennan (1997) who successfully treated a boy in a dissociative coma following war trauma using a variety of modalities, including hypnotherapy, computer-assisted communication and art therapy. Therapists are advised to be open-minded to a variety of approaches and take the best from

each in dealing with the challenges of any individual child or adolescent.

V. THEORETICAL BASIS

There is no consensus yet on the exact etiological pathway for the development of dissociative symptomatology, but newer theoretical models stress impaired parent-child attachment patterns (Barach, 1991; Liotti, 1999; Ogawa, Sroufe, Weinfield, Carlson & Egeland, 1997) and trauma-based disruptions in the development of self-regulation of state transitions (Putnam, 1997; Siegel, 1999). Newer theorizing ties maladaptive attachment patterns directly to dysfunctional brain development which may inhibit integrative connections in the developing child's brain (Schore, 2001; Stein & Kendall, 2003). From the vantage point of treating children and adolescents, a developmental understanding of dissociation makes the most sense. That is, dissociation may be seen as a developmental disruption in the integration of adaptive memory, sense of identity, and the self-regulation of emotion. According to Siegel (1999), integration is broadly defined as "how the mind creates a coherent self-assembly of information and energy flow across time and context" (p. 316). In other words, Siegel sees the development of an integrated self as an ongoing process by which the mind continues to make increasingly organized connections which allow adaptive action.

Children and adolescents may present with a variety of dissociative symptoms that reflect a lack of coherence in the self-assembly of mental functioning:

1. Inconsistent consciousness may be reflected in symptoms of fluctuating attention, such as trance states or "black outs."
2. Autobiographical forgetfulness and fluctuations in access to knowledge may reflect incoherence in developmental memory processes.
3. Fluctuating moods and behavior, including rage episodes and regressions, may reflect difficulties in self-regulation.
4. The child's belief in alternate selves or imaginary friends that control the child's behavior may reflect disorganization in the development of a cohesive self.
5. Depersonalization and derealization may reflect a subjective sense of dissociation from normal body sensation and perception or from a sense of self.

Dissociative symptoms have been found to correlate with traumatic histories of significant sexual abuse and/or physical abuse (Trickett, Noll, Reiffman & Putnam, 2001; Macfie, Cicchetti & Toth, 2001; Coons, 1996; Hornstein & Putnam, 1992; Dell & Eisenhower, 1990), as well as war trauma (Cagiada, et al., 1997) and natural disasters (Laor, Wolmer, Kora, Yucel, Spirman & Yazgan, 2002.) Dissociative symptoms in children have also been associated with parenting styles described as neglectful (Brunner, Parzer, Schuld & Resch, 2000; Ogawa et al, 1997; Sanders & Giolas, 1991), rejecting and inconsistent (Mann & Sanders, 1994). However, it must be noted that each child's reaction to life events is a constructive process that is idiosyncratic, and what might overwhelm one child may not overwhelm another. While not all trauma necessarily results in dissociation, events which have not necessarily been defined as major trauma

(e.g. repetitive losses of attachment figures, peer rejection, observation of domestic violence, medical procedures, chronic living instability, emotional abuse) have nevertheless been found in the backgrounds of children displaying dissociative symptoms. There may be individual differences in children's susceptibility to dissociative symptoms which may be related to other traits, such as fantasy-proneness (Rhue, Lynn & Sandberg, 1995) or other inherited personality traits (Jang, Paris, Zweig-Frank & Livesley, 1998). Considerable controversy remains as to the contribution of genetic factors in the development of dissociative symptoms (Grabe, Spitzer & Freyberger, 1999).

According to Siegel (1999), "interpersonal processes can facilitate integration by altering the restrictive ways in which the mind may have come to organize itself" (p. 336). Therapeutic intervention, therefore, can aim to provide those new interpersonal relationships which foster the integration and coherence of self, and improve adaptation.

VI. ASSESSMENT

In assessing the severity of dissociation, it is important to determine how disruptions of identity, consciousness or memory impede the achievement of normal developmental tasks. In the best case scenario, a child's self-disclosure about fragmented identity or discontinuous experience may allow a sensitive therapist to help the child acknowledge previously disowned affect and experiences, minimize self-destructive and disruptive behavior, increase personal responsibility, and eventually achieve developmentally normal integration. Those assessing children and adolescents should keep this therapeutic goal in mind.

A. General Framework

Diagnosis may include the following components:

1. Screening tests
2. Clinical interviews *
3. Structured clinical interviews
4. Psychological testing
5. Comorbid conditions *
6. Medical evaluation *
7. Pharmacological and hypnotic interventions
8. Ongoing assessment during treatment.

* these are essential.

1. Screening tests:

These are useful, though neither essential nor diagnostic, and may alert the clinician to more depth interviewing of child and caregivers regarding dissociative symptoms and experiences:

- a. Self-report questionnaires for the child include the Adolescent Dissociative Experiences Scale (A-DES; Armstrong, Putnam, Carlson, & Libero 1997; Smith & Carlson, 1996; Farrington, Waller, Smerden, Faupel, 2001), the Children's Perceptual Alteration Scale (CPAS; Evers-Szostak & Sanders, 1992), and the Dissociative Questionnaire (DisQ; Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993). One self-report questionnaire that may prove to be diagnostic is the adolescent version of the Multi-Dimensional Inventory of Dissociation (MID; Dell, 2002; Ruths, Silberg, Dell & Jenkins, 2002).

- b. Caregivers may be screened about dissociative behaviors with the Child Dissociative Checklist (Putnam, Helmers & Trickett, 1993), which has excellent validity and reliability (Putnam & Peterson, 1994).

2. Clinical interviews:

A complete history, from reliable informants as well as from the child, is the basic starting point for assessment. In interviews of the child, the family, and of other third parties, pay attention to the following:

- a. imaginary friends and other transitional objects, auditory and visual hallucinations, perplexing forgetfulness, intrusive thoughts and feelings, numbing, anxiety, nightmares, self-injury, flashbacks, somatic concerns, sexual concerns, depersonalization and derealization, and identity alteration and confusion (see Symptom Assessment below). Fairly structured interviews have been described (Lewis, 1996; Hornstein, 1998) as have cautions in interviewing (Silberg, 1998c).
- b. The family environment: physical and emotional safety; dysfunctional family patterns; history of psychiatric illness of all family members; family secrets that may impact on the child; sources of support outside the immediate family; practices or beliefs which are unusual for the family's culture and ethnicity.
- c. Areas of specific relevance to dissociation: the child's familiarity with material about dissociation from books, movies or family conversations; the family's investment or interest in, or understanding of, dissociation; multi-generational history of dissociation (Braun, 1985; Coons, 1985; Yeager & Lewis, 1996).
- c. the child's functioning in other settings, e.g. school, with peers.
- d. balancing predisposing, precipitating and perpetuating factors. The latter includes current life circumstances that maintain the disruptive symptoms, even if the dissociative patterns were established at an earlier age. Perpetuating factors are important for appropriate treatment planning, as families may try to focus exclusively on the child's past history and resist looking at their own current dysfunction.

3. Structured clinical interviews:

No diagnostic interview schedules have been validated for children and adolescents. However, the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994) has been used for adolescents who can maintain adequate attention and have an average or higher level of cognitive functioning (Steinberg & Steinberg, 1995; Carrion & Steiner, 2000).

4. Formal psychological testing:

This is not diagnostic, but may be corroborative. Behavioral signs and response features typical of dissociative patients include forgetting, traumatic imagery, and evidence of a passive problem solving style (Silberg, 1998b).

5. Comorbidity assessment:

Comorbidity is common with dissociative disorders. Current

practice guidelines (American Academy of Child and Adolescent Psychiatry, 1998) may be helpful in screening for: Obsessive-Compulsive Disorder (OCD), eating disorders, PTSD, reactive attachment disorder (RAD), Attention Deficit Hyperactivity Disorder (ADHD), affective disorders, substance abuse disorders, and specific developmental disorders (Hornstein, 1998; Peterson, 1998).

6. Medical evaluation:

The evaluator must rule out general medical disorders that may mimic dissociative symptoms. These include seizure disorders, other neurological conditions, allergy, exposure to toxins, or legal or illegal drug effects (Graham, 1998; Lewis, 1996).

7. Pharmacological and hypnotic diagnostic probes:

- a. Sodium amobarbital or other pharmacological interventions are not recommended in the assessment of children and adolescents.
- b. There is mild support for the use of hypnosis as a diagnostic tool for assessing children and adolescents for DID or DDNOS (Benjamin & Benjamin, 1993; Kluff, 1985; Williams & Velazquez, 1996). However, there are legal complications in the United States of America which may also apply in other jurisdictions: the legal guardian must give explicit permission; risks must be explained, including legal risks regarding the possible inadmissibility of testimony in future court proceedings. For these reasons, hypnosis is recommended only as an urgent assessment/intervention strategy for reaching severely unresponsive children where other methods have been ineffective.

8. Ongoing assessment during treatment.

- a. The best assessment is that which takes place in the context of ongoing therapeutic work, where the child's receptivity to intervention can be continually assessed, and where multiple input from teachers, parents, and other observers of the child can be attained in an ongoing way.
- b. Assessment should be guided by pragmatic concerns about how to best interrupt disruptive behavior. The treatment team ought to plan frequent assessments of dissociative symptoms in order to gauge progress.
- c. Diagnosis may become a source of conflict and dissension among members of the treatment team. Sometimes dissension in a team replicates contradictory pulls within the family or child, and sensitivity to this level of analysis may encourage integrative problem solving for the team, the family, and the child.

B. Trauma Assessment

1. Dissociation and trauma.

There is a strong correlation between traumatic events and dissociative symptoms. Thus, some children will present for evaluation with both dissociative symptoms and a documented legal and social service history of trauma. But others will present with just the symptoms or the history, but not

both; still others will present with neither symptoms nor history.

- a. When there is a clearly documented trauma history, the child will not necessarily have dissociative symptoms, though such a history ought to prompt a closer examination for dissociation. The child may manifest instead the conditions commonly comorbid with dissociation (see above), without dissociative symptoms *per se*.
 - b. When there are dissociative symptoms, but no documented trauma history, or disclosures by the child, the family, or other witnesses to abusive acts, the presence of dissociative symptoms or disorders are not in themselves sufficient evidence of prior trauma, such as sexual abuse or other specific trauma.
 - c. The trauma history may be masked by the child's amnesia, the family's denial, or the lack of records. Later disclosure by the child, the family or other witnesses to abusive acts may occur over the course of an extended assessment period.
2. Keeping the foregoing in mind, the clinician ought to conduct a thorough assessment of traumatic events in the child's history. This would include
- a. physical abuse, sexual abuse, emotional abuse, painful peer rejections, witnessing violence, and involvement in organized criminal activities such as child pornography or sex rings (Bidrose & Goodman, 2000).
 - b. neglect, inadequate attachment.
 - c. loss: death of a parent, loss of a parent through separation, other losses or experiences with death, illnesses of the child or other family members.
3. Cautions in assessment:
- a. Keep in mind multiple hypotheses about the reasons for reports of seemingly bizarre and improbable traumatic events, including that they may be true (Everson, 1997). Beware of inaccuracy, distortion, manipulation, deceit, or confabulation which may affect the child or family's report of trauma. Continue to assess and reassess as new information becomes available.
 - b. Avoid suggestive questioning in evaluating children's responses in interview (Coulborn, Faller & Everson, 1998; Fivush & Schwarzmüller, 1995; Goodman & Bottoms, 1993; Peterson & Biggs, 1997).
 - c. Follow professional guidelines (American Professional Society on the Abuse of Children, 1997; American Psychological Association, 1998).
3. Trauma and amnesia.
- a. Some autobiographical amnesia is a normal developmental phenomenon (Siegel, 1996).
 - b. While the frequency of traumatic amnesia in children and adolescents is unknown, clinical experience suggests that children and adolescents may have sudden recall of previously unavailable traumatic memories during or

outside of therapy sessions. This process has been documented in cases where the traumatic events were corroborated (Corwin & Olafson, 1997; Duggal & Sroufe, 1998).

- c. Because children's memory is enhanced from practice and rehearsal and is superior for events that are familiar (Ornstein, 1995), sexual abuse experiences, may not be as accessible to recall, especially when shrouded in secrecy.
- d. Memory for traumatic events for children in incestuous families may also be affected by the intense contradictory pulls for attachment and for safety, when the source of abuse is also the source of nurturing (Freyd, 1996). In addition, violent threats from a perpetrator may produce powerful incentives to dismiss certain traumatic events from conscious awareness so that a child can more effectively cope with day-to-day expectations.
- e. Children may lack verbal memories for traumatic events, but display knowledge of events through sensori-motor modalities or somatic symptoms instead (Burgess, Hartman & Baker, 1995; Fivush, Pipe, Murachver & Reese, 1997; Stien & Waters, 1999; Terr, 1991). Evaluators ought to be sensitive to how children's play, art, behavioral re-enactments, and somatic concerns may be reflections of or communicate information about traumatic events.

4. Just as with the assessment of dissociative symptoms, in taking a trauma history attention to past stressors ought to be balanced by attention to current stressors (perpetuating factors), as these may promote continued dissociative adaptation.

C. Symptom Assessment:

In assessing the severity of dissociative symptoms, take into consideration how severely the symptom disrupts normal developmental experiences like playing with friends, or attending school, and how far the child's behaviors and experiences deviate from what is characteristic of normal developmental phenomena.

1. Trance states.

Trance states or "black outs" may span the range from momentary absences of attention (normal in children and adolescents), to longer periods of non-responsiveness, to excessive sleeping or fainting, to states described as coma (Cagiada et al., 1997). Determine what elicits these absences in attention, how long they last, what seems to interrupt them, what consequences these disruptions have for the child, and what the child experiences during these states.

2. Amnesia and transient forgetting.

True amnesia about one's own recent behavior is quite rare, and diagnostic of a more severe dissociative process. More common is amnesia for past traumatic events. More common still is transient forgetting which quickly disappears after the child is working with an empathic therapist; e.g. parents may report the child has no memory for an event; children may use the expression "I forget" as a distraction, out

of guilt or shame, or because of lack of rapport with the interviewer.

Asking children about whether they forget good things (good grades, birthday parties), as well as misbehavior or angry episodes (Hornstein, 1998) may help discriminate between amnesia and unwillingness to report.

Other useful techniques for assessing memory problems are the following:

Gently inquire with the parent out of the room.

Help the child express feelings associated with the forgotten behavior.

Role-play the forgotten behavior.

Provide abundant contextual clues.

Decrease the child's sense of shame.

3. Imaginary playmates.

Take special care to differentiate normal imaginary playmates and fantasy material from pathological dissociative symptoms. Dissociative pathology is suggested when the involvement in fantasy interferes with normal activity, when the child feels his behavior is outside of his/her control, when he/she experiences the imaginary playmates as real, and when the child perceives imaginary figures in conflict with each other (Silberg, 1998c; Trujillo, Lewis, Yeager & Gidlow, 1996).

4. Identity alteration and changes of state.

Some children may feel the presence of internal others, alters, ego states, self states, personalities, etc. (for the purpose of these Guidelines, all these terms are synonymous). Don't be too suggestive in questioning as this may encourage the child to feign behavior to please the evaluator; use child-familiar language.

Instead of encouraging the child or adolescent to switch to alternate identities, or "self-states" (Peterson, 1996), encourage the child to make the internal connections that promote awareness of other states, affects, or identity shifts.

If a child is observed to shift behavior or affect spontaneously during the evaluation without direction from you, try to determine which stimuli elicited the shifts in state and to understand the functions of the state switches for the child (i.e., avoidance, encouraging caregiving behavior, expression of rage). Then evaluate the child's memory for the state change, and help the child make connections between feelings and behaviors and explore alternative coping strategies. That being said, some therapists argue that refractory cases of severe dissociation in adolescents may require more directive assessment and interventions (Kluft, 2000).

5. Children normally go through changes in affect and behavior during the course of an interview. Be careful not to over-pathologize normal state shifts. Inquire about the subjective sense of discontinuity and about any stimuli that preceded a change in state, mood, ability or perceived identity. Frequently, the stimulus may be a feeling associated with a traumatic event or associated thought which children find too frightening or embarrassing to acknowledge. Children with dissociative symptoms often have very colorful ways of describing these phenomena that make it clear that their changes feel to them dramatic, uncontrollable, and puzzling.

Even during the assessment, try to connect these initially puzzling changes with the child's own perceptions, feelings, goals, intentions, and communicative meanings, even if these are not at first obvious. Making these connections even during assessment will give you a better idea of the child's receptivity to therapy and the severity of the dissociation. Shifts that are dramatic and perplexing to the child and may involve sudden regression, rageful behavior, apparent loss of consciousness, or suddenly talking about oneself in the third person or with a new name are shifts that suggest difficulty in the integration of affect, consciousness, and identity and are consistent with DID. Assess the family's and others' reactions to these shifts for a context for understanding some of the ongoing shaping influences that may promote dissociation.

6. Depersonalization, derealization, substance abuse.

Some feelings of transient depersonalization are common in adolescents. Distinguish this from depersonalization and derealization complicated by substance abuse, which may contribute to it (Carrion & Steiner, 2000).

7. Somatic symptoms.

Inquire about somatic symptoms (e.g. headache, stomach aches, other undiagnosed pain) as well as somatoform dissociation, which includes symptoms of loss of physical sensations, unusual pain tolerance or pain sensitivity, and other sensori-perceptual anomalies (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996).

8. Post-traumatic symptoms.

These include positive symptoms, such as nightmares, night terrors, disturbing hypnagogic hallucinations, intrusive traumatic thoughts and memories, re-experiencing or flashbacks, and traumatic re-enactments; as well as negative symptoms, such as numbing and avoidance.

Standardized screening instruments such as the Trauma Symptom Checklist for Children (TSCC; Briere, 1995), The Trauma Symptom Checklist for Young Children (Briere, Johnson, Bissada, Damon, Crouch, Gil, Hanson, Ernst, 2001) or the Children's PTSD Inventory (Saigh, Yasik, Oberfield, Green, Halmandaris et al., 2000) may also assist with this evaluation (see also Nader, 1997).

9. Sexually reactive or sexual offending behaviors may occur in traumatized children and may co-occur with dissociative symptomatology. Distinguish between normal sexual behaviors, sexually reactive, and sexually molesting behaviors in children and adolescents and evaluate the role dissociation plays in the maintenance of these (Johnson, 2002; Friedrich, Gerber, Koplin, Davis, Giese, Mykelbust, Frackowiak, 2001).

10. Self-injurious behavior is common among dissociative teens which may include cutting, burning, scratching, or head-banging. This behavior may be secret, may serve an affect-regulating function, and may be performed in a dissociative trance state, or used to facilitate or interrupt such a state. Gently inquire about all stages of self harm (cutting, burning, hitting, etc.), i.e. planning, preparing, doing, and recuperation, as some or all stages may be done in a dissociated state (depersonalized, numbed, trance state, robotic state,

dream-like state, etc.). Inquire as to relief experienced by such self harm, as the infliction of external pain commonly reduces internal pain.

VII. TREATMENT

A. Length and Course of Treatment

1. Most child and adolescent cases of severe dissociation are not as difficult and lengthy as adult cases. An optimistic attitude facilitates recovery. Despite the refractory nature of many adolescent cases (Dell & Eisenhower, 1990; Kluft & Schultz, 1993), there are many cases of successful outcome as well (Dell & Eisenhower, 1990; Silberg & Waters, 1998; Silberg, 2001a; Silberg, 2001b; Silberg, 2001c). Adolescent therapy in cases of unstable families may have more limited goals of crisis intervention and promotion of stability with intermittent services (Wieland, 1997). With younger children in unstable homes, treatment efforts should work to stabilize placements.
2. Length or frequency of treatment cannot be prescribed, but must rely on the severity of the patient and family circumstances and family constraints. It is appropriate to maintain an open-minded and hopeful stance about the possibility of rapid treatment, even for the most severe presentation, as this has occurred in many cases (Kluft, 1984, 1985; Peterson, 1996; Silberg & Waters, 1998). In some cases, treatment can be intermittent as the child's needs change.
3. The therapist must assess at the outset the availability of resources and plan for the eventuality of more restrictive services, if needed (Kluft, 1996). However, multi-disciplinary coordination can often prevent the need for more restrictive services.

B. Role of the Therapist

1. Therapists must forge an empathic connection with the whole child, including disowned experiences and affects that the child may perceive as being contained in voices, imaginary friends or self-states, so that the child feels fully accepted at all levels of experience. This empathic connection is key for the child to begin to accept his/her disowned experience and affect and to take responsibility for moving on.
2. Continuity in the therapist's relating to the child across all changes of state is a key ingredient in the therapy.
3. Treatment of children and adolescents with the severity often presented in these cases is often a team effort, involving parent, therapist, school, pediatrician, and any significant others involved in the case. Therapists must acquaint themselves with all members of the team and develop a format for regular communication. No child can be fully treated in isolation, and consistency in approaching the child within all settings may help to promote integration and defeat dissociative barriers. Communication within the team should focus foremost on safety and support for the child and development of consistent expectations for the child, as well as on understanding the internal influences which affect the child's ability to contain destructive or disruptive behaviors.
4. As with all treatment of children, the therapist must balance

confidentiality offered to the child with the legal rights of custodial parents for access to records and to information that may have life-threatening implications and must disclose policies regarding this to both child and parent at the outset of therapy.

C. *Special Cautions in the Treatment of Dissociative Symptomatology*

The following are common pitfalls in working with dissociative children and families:

1. Achievement of physical safety is a primary goal that supersedes any other therapeutic work. Reports to local child protection services are required whenever issues of child maltreatment are suspected. Clinicians must follow reporting guidelines within their own regional jurisdictions. In cases where the therapist concludes that current legally-dictated arrangements are not in the child's best interest, it is the therapist's obligation to provide recommendations to the child's current caregiver, advocate, case worker, court-appointed attorney, or guardian *ad litem* regarding the therapist's findings.
2. The therapist should recognize his/her role as a potentially powerful reinforcer and shaper of the child's or adolescent's behavior. A stance of gentle, empathic, non-judgmental listening and open inquiry may encourage children to describe in their own language the contrasting influences, imaginary friends or self-states that they perceive as affecting their behavior.
3. An important goal of therapy is for the child to learn increasingly adaptive and flexible ways to manage affect and to integrate past, current, and new experiences so that development is not compromised. The child should be encouraged to participate in normalizing activities such as sports, art, or music. If the child appears to be regressing in therapy, the therapist should review the course of treatment, evaluate safety in the environment, evaluate possible stressors (e.g., court testimony, visitations, too much focus on traumatic events), and seek other consultations regarding how to modify the treatment approach so that the child is progressing along a developmental trajectory that is as normalizing as possible.
4. Overly special or zealous interventions (e.g., isolating children from peers or school for long periods of time, physical restraint systems) tend to reinforce dissociation rather than curb it, and may support a family's or system's entrenched beliefs about a child's incapacities.
5. Families may defensively concentrate on the past and avoid discussion of the current stressors that maintain dissociative adaptations. The therapist should help the family find creative solutions to current problems, while exploring feelings from past events that continue to contribute to current difficulties.
6. All treatment should include intervention with the family currently providing care to the child or adolescent. The family needs to be helped to understand the child's fears and underlying anger without accepting these as excuses for irrespon-

sible behavior. This intervention can occur as part of the regular therapy or from a separate family therapist with close coordination. Therapists should stay alert to the need for referral of the parents for treatment when the parents' own mental health issues interfere with the child's treatment.

7. The therapist must help the child and the family understand that any self states or alternate identities are really part of the child and that the whole child is responsible for his/her behavior. The child as one, unified, responsible person must be emphasized. The family needs to be encouraged not to ask for the "good child" or the "good behavior" but to interact with the child as a whole, while assisting the child to accept responsibility for the disowned behavior or affect. The therapist can help the child gain increasing control over the behavior, and the adults must be cautious not to unwittingly increase dissociation through undue emphasis on separateness.

D. *Therapeutic Goals*

1. **Help the child achieve a sense of cohesiveness about his affects, cognitions, and associated behavior.** Although the child may perceive his/her emotions and behavior as outside of his/her own control, the therapeutic goal is to increase in the child a sense of awareness of his/her feelings and responsibility for associated behavior. The therapist gently but firmly should help the child to accept responsibility when limits are imposed for behavior that feels outside of his/her control, and parents must continue to impose these limits despite the child's sense of frustration. This frustration is, in part, what stimulates the internal awareness (or co-consciousness) that leads to change. When the child perceives that the behavior is controlled by an imaginary friend or other dissociated aspect of the self, treatment gently highlights the motivations, memories and feelings which the child has had trouble integrating into central awareness and, over time, this promotes a cohesive and integrated sense of self.
2. **Enhance motivation for growth and future success.**
 - a. Help the child believe in his/her own skills and potential. Enhance motivation for success and future accomplishment. This promotes integration and helps defeat the resistance to change.
 - b. Educate about how dissociation prohibits growth and change. This encourages the child to abandon dissociative strategies over time.
3. **Promote self-acceptance of behavior and self-knowledge about feelings viewed as unacceptable.**
 - a. Dissociation may protect the child from awareness or experience of his/her own feelings of rage, disappointment, grief, self-doubt, fear, shame, physical pain or sexuality. Enhancing knowledge about these helps promote integration. Education about sexuality (Wieland, 1998) and affect may assist with this process. Education on early implicit memories, and how they can affect one's developmental integration, can also help both

children and parents understand the child's experience of dissociation.

- b. Gestalt techniques involving dramatizing and thus giving voice to a variety of opposing feelings (Shirar, 1996; Waters & Silberg, 1998a, 1998b) may stimulate this process of self-awareness and promote acceptance of dissociated feelings.
- c. Model the acceptance of all contrasting feelings, and remind the patient of these feelings when they are not immediately accessible. This helps break down dissociative barriers.

4. Help the child resolve conflicting feelings, wishes, loyalties, identifications, or contrasting expectations.

- a. The child may perceive these as conflicts between internal voices, imaginary friends, or conflicting identities. The therapist helps the child find ways to express these conflicts directly, examine both sides of the conflict, and problem-solve towards integrative solutions, so that over time there is no longer a need for dissociative escape or a fragmented sense of identity.
- b. Play therapy in which these various conflicts, contrasting role expectations or dissociated feelings are enacted in play, and brought to conscious awareness by the therapist's comments, can encourage a natural integration and development of cohesive identity in younger children (Albini & Pease, 1989; Laporta, 1992). This may be facilitated by specific play activities, or by imagery and hypnotic techniques (Gil, 1991; Shirar, 1996; Waters & Silberg 1998b; Kluft, 1985; McMahon & Fagan, 1993). With teenagers, some therapists recommend having the client write letters to him/herself or dramatize aloud internal dialogues to facilitate resolution of competing wishes or feelings. These exercises promote self cohesion without reinforcing the separateness of identities. Therapists should take note of situations where these conflicts cannot be resolved without a concomitant change in the environment. For example, children may be caught in custody battles, with widely divergent expectations between parents, that may lead to a fragmented sense of identity. The child alone cannot resolve this unless the environmental pressure is relieved.

5. Desensitize traumatic memories, and correct learned attitudes towards life resulting from traumatic events.

- a. Talk to the child about overwhelming experiences and their associated affects and perceptions. This helps to desensitize the child's conditioned fear responses to any frightening memories. The child's access to these memories may be variable as treatment progresses. However, as the child moves towards a more cohesive sense of self, such memories may become more accessible. Be careful to titrate discussions about traumatic content and not overwhelm the child (James, 1989). Eye Movement Desensitization and Reprocessing (EMDR) can assist children in working through experiences for which they have very little or no explicit memory or experiences that they find too difficult to talk about in

detail (Tinker & Wilson, 1998; Greenwald, 1993). Ego-strengthening and calming techniques are advisable prior to using EMDR to avoid destabilization. When dealing with traumatic content, techniques that help improve the child's sense of efficacy and mastery are encouraged (Gil, 1991; Gil, 1996; James, 1994; Friedrich, 1991). Play therapy with trauma patients tends to involve more active intervention for re-working of traumatic themes than other kinds of play therapy.

- b. Traumatic re-experiencing may take the form of flashbacks, in which the child or adolescent experiences past events as if they were really happening. Imagery techniques (Wieland, 1998) or formal hypnosis to guide the child towards mastery experiences (Williams & Velazquez, 1996; Friedrich, 1991) may be helpful. Families can set designated times to discuss unpleasant memories so that these do not interfere with daily functioning (Waters, 1998). Some traumatized children engage in flashbacks during parental fights or when asked to do chores, so understanding the complete context in which these flashbacks occur is essential before recommending interventions.
- c. Traumatized children may develop a variety of learned attitudes which may include helplessness, belief in a bad self, being destined for bad things, and being unlovable, and these beliefs need to be corrected in the therapy (American Academy of Child and Adolescent Psychiatry, 1998; Deblinger & Helfin, 1997; Wieland, 1997). Dissociative children may hold contradictory beliefs, or contradictory attachment styles (Liotti, 1999) with associated beliefs which may make this aspect of treatment particularly challenging. Gently pointing out these contradictions within the context of an accepting therapeutic relationship eventually leads to integration.

6. Promote autonomy and encourage the child to independently regulate and express affects and to self-regulate state changes

- a. Therapists can help children identify precursors to state changes so that they become better at self-monitoring (Allers & White; Gil, 1991; James, 1989).
- b. Self-injury may become a mood-altering addictive behavior which serves to distract from emotional pain or express feelings of despair and anger. Children engaging in repetitive self-harm must learn alternatives such as more direct feeling expression, improved methods of mood regulation, and families must assess ways in which they can learn to reinforce positive methods of affect-regulation.
- c. Self-monitoring may be encouraged by use of special code words whereby a parent or teacher can let a child know a shift has occurred or these words or slogans can stimulate focused attention. Cognitive-behavioral techniques can help children learn to manage self-destructive and impulsive behavior, including impulsive sexual behavior. Children can be reinforced for identifying changes in moods or states, interrupting dysfunc-

tional impulsive habits, and engaging in drawing, writing, talking to adults, or other expressive alternatives. Therapists can teach children techniques of promoting active attention which may help interrupt sexual misbehavior or other disruptive behavior that occurs during dissociative states (Johnson, 2002). Teaching use of positive imagery and relaxation for self-soothing and stress reduction may be useful.

7. Promote healthy attachments and relationships through direct expression of feelings.

- a. Encourage children to communicate feelings of anger, fear, and regressive needs to their caregivers so that these are not enacted in dysfunctional ways. Teach caregivers to tolerate these direct expressions. This promotes healthy attachment though it may be difficult for families that are uncomfortable with affect and have poor boundaries.
- b. Help families and children view the therapist as a stable attachment figure, particularly for children and families from chaotic environments.

E. Adjunctive Treatments

1. Family Therapy

- a. Work with the primary caregivers may include education about dissociation (Waters, 1998), specific guidance about parenting strategies which facilitate therapy (Boat, 1991), family sessions to encourage the family to accept all aspects of the child (Waters & Silberg, 1998b), correcting interactive patterns that promote dissociation (Benjamin & Benjamin, 1993; Silberg, 2001), helping parents process guilt or denial about traumatic events (Keren & Tyano, 2000; Silberg, in press), working through of feelings about issues of safety and betrayal to help establish trust (Waters, 1998), and straightforward parenting advice or training which is part of all good child therapy.
- b. In educating parents, change any literal views the family may have about the reality of “alters” as separate from the child, while explaining how dissociation evolves in a traumatized child. Parents can be taught to encourage the child’s direct expression of thoughts and feelings without reinforcing dysfunctional dissociative strategies. The therapist can also help the family identify current reinforcers that maintain the symptomatology, such as family indulgence or overly punitive responses in the face of regressive behavior.
- c. For children residing in original homes in which maltreatment or unintentional exposure to traumatic events occurred, acknowledgment of the trauma and an apology for the lack of protection is a basic starting point for much of the family therapy work
- d. Dyad work with the parent figure and the child can be particularly valuable in helping the therapist understand the subtle negative dynamics that may be occurring in the home. This would be a time when the therapist, parent and child can develop ideas for handling problem

situations at home.

2. Hypnotherapy

Hypnotherapy for children and adolescents has been described for rapidly accessing ego states and promoting integration (Bowman, Blix & Coons, 1985; Dell & Eisenhower, 1990; Kluft, 1985; Kluft, 2000) or for containment of intense affect, ego strengthening, education, and support (Williams & Velazquez, 1996), but hypnotherapy is not advised for memory retrieval. In cases where hypnosis is deemed appropriate, the therapist should gain informed consent from caregivers or guardians, as well as clients. The therapists should explore all legal implications, given that witness credibility for any upcoming court hearings could be affected.

3. Pharmacotherapy

- a. There are no controlled studies on the use of medications with dissociative children, adolescents or adults.
- b. Some clinicians have found that psychotropic medication may be of benefit for children and adolescents with dissociative symptoms and disorders as an adjunct to psychotherapy to ameliorate targetable symptoms, such as incapacitating anxiety, insomnia, lability, behavioral dyscontrol, inability to focus attention, and depression (Nemzer, 1998; Putnam, 1997; Silberg, Stipic & Taghizadeh, 1997; Putnam, 1997).
- c. Medications may be utilized to treat co-morbid conditions such as attention deficit hyperactivity disorder (ADHD), major depression, OCD, or PTSD.
- d. Close communication and teamwork between the prescribing physician and the therapist is essential.

4. Art Therapy.

Strike a balance between art that encourages mastery and art that is regressive, limiting the latter if it simply becomes a form of traumatic re-enactment without trauma resolution. Most child therapists use some art in their work, and art therapy from a licensed art therapist may be a useful adjunct to individual treatment in some cases (Sobol & Schneider, 1998).

5. Group therapy.

Group therapy may be useful, particularly if it is psycho-educational in orientation (Brand 1998; Silberg et al, 1997). Promoting positive peer interactions may help build in long-term resiliency for children and adolescents.

6. Inpatient/Residential Treatment

- a. Admit dissociative children and adolescents to inpatient care when they are engaged in dangerous, self-injurious or destructive behavior that cannot be contained in a community environment, or where the child is at risk and needs a safe environment for a complex assessment (Hornstein & Tyson, 1991). However, avoid hospitalization, if possible, through close monitoring, more frequent sessions during a crisis, or respite care.
- b. Admit the child or adolescent to residential treatment if he/she requires ongoing close monitoring and a care-

fully structured environment for his/her own protection or protection of others. A more intensive treatment milieu may be needed for stabilization, processing of traumatic material, and learning appropriate problem-solving.

- c. The goal of the inpatient or residential treatment is to stabilize behavior by identifying the internal motivation for the dangerous behavior, which may not be readily accessible to the child if dissociated from awareness, and negotiating and resolving internal and external conflicts until commitment to safety is achieved.
- d. If seclusion or therapeutic physical containment is required for destructive behavior, it is essential that these procedures be explained to children in advance. Once calm, such episodes may be worked through with the child or adolescent, so that they can best identify traumatic associations or internal and external stimuli that prompted this behavior. The child's belief that other parts of the self were responsible for the misbehavior should not be viewed as the child willfully escaping responsibility, as this stance may serve to increase oppositional behavior. Instead, the child should be gently encouraged to take ownership of the feelings associated with the destructive behavior, while exploring constructive ways to gain control. If the child presents as having no memory for the experience, the staff can gently explain what the behavior involved, and follow through with appropriate consequences.
- e. The hospital or residential center must have the structure to provide protection to the child from his/her destructive impulses, which may be directed towards the self or others, and from re-traumatization from other residents or patients.
- f. Staffmembers dealing with dissociative children and adolescents should have basic familiarity with dissociative and post-traumatic reactions and know how to help children with the experience of flashbacks and post-traumatic anxiety.
- g. An approach that deals only with observed behavior and is based solely on behavior modification will in most cases be inadequate. This kind of approach will not assist with identifying the feelings, traumatic stimuli, or internal states that led to the destructive behavior. It is important to help the child plan for future similar events, so that the child achieves the self-control necessary to move to a less restrictive environment.
- h. The setting should provide close cooperation with the child's outpatient therapist, protective service workers,

or legal advocates, to provide for a smooth transition to discharge.

7. Educational interventions.

- a. Children and adolescents with dissociative symptoms may require special education modifications if their disruptive behavior, mood instability and poor attention interfere with academic functioning. With supportive staff, however, many children with dissociative symptoms can succeed in regular classrooms.
- b. School staff should help encourage the child or adolescent to stay focused even while mood and attention fluctuate. It should be assumed that the child or adolescent will bring his/her full potential to the school setting, and an attitude of gentle accountability is encouraged. The school staff should convey an attitude of understanding and reward effort and approximations of desired goals. Pre-arranged code words or signals that stimulate attention and focus may be useful.
- c. The staff should encourage children and adolescents to monitor themselves to access the greatest potential possible, should set clear and firm limits about expectations, and provide regular opportunities for the child to communicate about sources of stress in the school environment or at home that may impact on performance.
- d. Discourage special attention from other students related to extreme shifts in behavior. Designate one member of the staff to deal with any dramatic shifts, such as age regression.
- e. Incorporate expressive arts into the curriculum for expression of feelings (Waterbury, 1998).
- f. Be attentive to the children's needs to have stable attachment figures in the school setting (counselors, advisors, or teachers) with whom they have a special relationship and with whom they can communicate frequently (Kobak, Little, Race, Acosta, 2002).

VIII. SUPPLEMENTARY ISSUES

Refer to the Adult Guidelines published by the ISSD for questions addressing discussion of fees, relationship with the media, boundary issues and spiritual and philosophical issues. In addressing any of these issues with the child or adolescent, be sensitive to the patient's emotional and cognitive as well as chronological developmental level. Approach parents or caregivers of children and adolescents in treatment with consideration for boundary management, dual relationships and protection from exploitative relationships.

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²Chairperson: Joyanna Silberg, PhD. Members: Frances Waters, Elaine Nemzer, Jeanie McIntee, Sandra Wieland, Els Grimminck, Linda Nordquist, Elizabeth Emsond. The committee thanks Peter Barach, James Chu, John Curtis, Beverly James, John O'Neil, Gary Peterson and Margo Rivera for critical comments and suggestions.