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President's Message

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An Optimistic Look at Childhood Dissociation

My work with children and adolescents with dissociative symptoms and disorders is often extremely rewarding, as I have the opportunity to see dissociative processes reversed and resolved before my eyes. Intense self-destructive behavior, belief in imagined identities, and fluctuating states of awareness can evaporate and I have an opportunity to watch my patients move on with productive lives without the burden of these debilitating psychiatric symptoms.

The perspective of work with the younger population may give all clinicians some insight into the processes underlying dissociation and its remediation. I would like to share a clinical anecdote with you and explore some of the reasons why work with this population may often produce positive outcomes more quickly. Perhaps some of my observations may have applications to work with adult clients, or better yet, perhaps I will convince some of you to work with the younger population, a particularly under served clientele.

One reason that dissociative disorders in children and adolescents may be easier to treat is that most likely the severe forms of dissociative disorder such as DID develop and consolidate with rehearsal and practice of dissociative coping strategies over time. I believe increasingly hostile and lonely environments that make real connection and relationships impossible further encourage the consolidation of dissociative symptoms.

The Putnam, Hornstein, & Peterson (1996) review of 177 dissociative children and adolescents indicated that the older the children the more closely their symptomatology resembled adult forms of the disorder, suggesting that a developmental process contributes to the evolution of the adult-like syndromes. I had the opportunity to observe the natural development of this pathological process in a child I had seen at age five, who took an eight-year hiatus from treatment and then returned to me at age 13. I was able to see firsthand how dissociative pathology can progress over time without intervention.

At five, Steven was obsessed with several imaginary figures, went into extreme destructive tantrums, and had many self-abusive behaviors. He had lived with an abusive father and stepmother for a year, and been a victim of both physical and sexual abuse before being returned to the custody of his mother. At five, Steven heard "Dino" (a dinosaur toy) talking to him and his aggressive behavior often followed his perception that "Dino" was commanding him to fight. Sometimes, he told me, he scratched and bit his arm as a way to silence "Dino." Steven also had an "angel" who sang to him in a feminine voice and told him not to fight, and a toy puppy that cried all the time for his "mommy." Steven was bright and adept at telling me about his imaginary world. Unlike normal children joyfully involved in their fantasy play, for Steven these phenomena felt all too real and troublesome.

After a few sessions, Steven began to describe physically abusive behavior of his maternal grandfather, who served as a babysitter while mother worked long hours. An initial report to social services led his mother to withdraw Steven from therapy. I had hardly had an opportunity to begin to help him.

I was quite surprised eight years later when Steven's mother called me, urging me to take him back as a patient. He was at this time confined to a children's detention center after being arrested for breaking into a neighbor's house and stealing several items. Before his arrest, he was aggressive to boys in the neighborhood, had been found selling stolen property, and was failing in his special education placement. Steven's mother urged me to evaluate him again, as she was unsatisfied with his current diagnosis of schizophrenia and wondered if I could help. She stated she always regretted having taken him out of my care, and reported that it had taken her several more years to realize the abusiveness of her own father. She had finally moved out and was trying to make a safer life for herself and her son.

> I never underestimate the impact of an environment that produces experiences of increasing success and of a family committed to making changes. These treatment components can no doubt facilitate more rapid recovery in patients across the whole life span.

When I evaluated Steven at 13, he reported, at first, no memory for his illegal behavior or his aggressive episodes. However, he stated that "Dino" would know about this, a "character" who he said inhabited his brain along with a "crying baby" and a "girl named Sue." At 13, his imagination and fantasy had become rigidly segregated into perceived alternate selves. What at five were simply some vivid fantasy experiences and troubling voices, at 13 presented more like a dissociative identity disorder. Dino was no longer a vivid fantasy toy, but was an internalized self-representation that acted

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out feelings of anger. Now strong enough to get revenge on others, Steven's self-abuse had been transfomed into the desire to hurt others. The puppy was gone, but in its place, Steven felt a regressive pull, and would often enact child-like ego states where he whined and cried for his mother. With a sense of shame, Steven reported that sometimes he felt like a girl, which was "good" because it helped him control his anger, but "bad" because others made fun of his tone of voice.

However, even at 13 Steven was rapidly treatable. Memory for his behavior as "Dino" was quickly achieved once Steven's real feelings of betrayal and anger at his mother and various adults in his environment were expressed directly. His mother was eager to work in therapy this time and help him deal with the betrayal of his past and her own inability to protect him through the years. Steven's mother was involved in ongoing therapeutic work to identify her own resources, to promote growth in Steven and to resist the urge to indulge his regressions, which both she and Steven found rewarding. Steven had used this regression as a coping tool to avoid blame and to attain immediate nurturing. Mom and Steven were trained to use other language and other interactions to satisfy Steven's need for affection and loving mothering. Steven was discharged from the detention center and placed in a special school where he received individual therapy, family therapy and an environment of structured consequences. After five months of treatment, Steven's perception of separate selves had evaporated, Steven had full memory for his behavior, and felt his regressions, anger, as well as his identification of "feminine qualities" in himself were all part of his own personality and shifting emotional life. Steven is now better able to talk about the traumatic experiences of his childhood, but does not feel that his life is dictated by these events.

What was Steven's treatment and how did it occur so rapidly? Steven had all of the components necessary for a successful therapy -- a high level of motivation, an extremely motivated mother, and a sensitive school environment with structured rewards for meeting goals. Steven's individual treatment first focused on having Steven set goals for himself and his future. Often the lack of belief in oneself and in a positive future severely hampers progress and leaves clients pathologically attached to their symptoms as security objects. Steven was able to identify a career goal in science and began to feel that this may be attainable for him as he received the support and assistance of a structured and individualized school environment. Steven's anger was channeled through communicating directly to his mother about what he had felt regarding her leaving him with the grandfather, and anger at the man whose house he had robbed, a friend of his grandfather. Steven identified traits in himself that were probably introjects of his mother and these were interpreted to him as positive forms of self-soothing rather than "acting like a girl."

Individual treatment focused on having Steven express directly the needs, feelings, and attitudes of these perceived other selves. Steven was encouraged to dialogue with himself, rather than to "switch," in order to explore the feelings and motivations that he had dissociated. Since central organization and control was a goal of treatment, the therapy encouraged his own mastery at controlling and understanding these states rather than enacting them for others. The practice in getting access to his dissociated feelings on his own allowed Steven to experience the feelings of these parts of self and soon to claim them as his own. Steven was actively involved in positive activities -- cooking, school work, and sports -- and his mind was filled with real-life challenges and experiences which left him little time for retreat into dissociative states.

All of this certainly sounds too easy. Can a child this impaired really turn his life around given structured opportunities for success and a cooperative family? Yes. Steven is not the only child who has made significant progress after coming to me with symptoms of severe dissociation. As I look at my successful cases, who are making good progress like Steven, I can identify a pattern of attitudes and opportunities which seem to promote healing.

Patients who can identify future goals and realistic points of achievement can more easily dispense with dissociative defenses that often protect from the fear of continued failure. Families who are willing to take action to reverse processes that promote dissociative coping styles can help children heal faster. In this case, mother's indulgence of the "baby Steven"and her inability to hear his real anger about the ways she let him down initially encouraged the dissociation of his feeling states. Yet, she was highly motivated to change these patterns.

The intense battle within can be soothed by a therapeutic approach of accepting with compassion the intense warring feelings that feel foreign to the self. Even the most debilitating symptoms like amnesia, aggression, breaking the law and regressions can be managed with compassion, enhancing motivation for success, coupled with firm limits. As rigid as the dissociative barriers may appear, believing they can be fluid may sometimes make them so. Finally, I never underestimate the impact of an environment that produces experiences of increasing success and of a family committed to making changes. These treatment components can no doubt facilitate more rapid recovery in patients across the whole life span.

"This article was written with the permission of "Steve" and his family. Names and identifying information were changed."

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