THE TREATMENT OF DISSOCIATION IN SEXUALLY ABUSED CHILDREN FROM A FAMILY/ATTACHMENT PERSPECTIVE

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This article outlines an approach to treatment of sexually abused children with dissociative symptoms. Dissociated self-states are seen as competing interpersonal approaches to handling the many emotional sequelae of abuse, including anger, fear, and regressive needs. Parents’ responses to their sexually abused children, complicated by guilt and their own histories of trauma, can promote dissociative coping in the children as they have difficulty processing their own real feelings of anger, fear, and responsibility. Children and parents may alternatively take victimizer, victim, and rescuer roles, thus mutually reinforcing a dissociative style of coping with these events. This article illustrates how sensitivity to these family dynamics, along with a problem-solving approach to the child’s symptoms, can treat dissociative psychopathology in these children.

Dissociative symptoms in children and adolescents have been described increasingly as a sequela of various traumatic experiences, including physical abuse, medical trauma, exposure to violence (Dell & Eisenhower, 1990), infantile neglect (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997), war trauma (Cagiada, Cammado, & Pennan, 1997), and sexual abuse (Coons, 1994; Johnson, 2002; Stien & Kendall, 2004). Dissociative symptoms may include a child entering trance-like states, showing forgetfulness for past or current behavior, having fluctuating behavior including rapid regressions, rage reactions, beliefs in vivid imaginary friends or divided identities, and symptoms of depersonalization and derealization. While theoretical writings have often associated dissociative symptomatology in children with sexual abuse experiences, studies have failed to demonstrate that there is a necessary or exclusive relationship between sexual abuse experiences and dissociative symptomatology (Ogawa et al., 1997; Rhue, Lynn, & Sandberg, 1995). Nonetheless, a history of sexual abuse is often found in children who display dissociative symptomatology, and treatment of patients with these histories can be enriched by an appreciation of the relationships between sexual abuse events and the manifestations of these various symptom patterns.

This article looks at dissociative symptoms in sexually abused children from a complex and multidimensional standpoint. The theoretical model underlying this treatment approach assumes that dissociative symptoms are complex adaptations that evolve into learned habits that are then reinforced in environments in which parent–child interaction patterns continue to promote and reinforce maladaptive functioning. The important role of families and how they deal with children’s sexuality, sexual behaviors, and sexual experiences is heavily stressed, as this is seen as the primary force that shapes dissociative adaptations in sexually abused children over time. While cognitive–behavior therapy has been em-
pironically validated for work with sexually abused children, it may be necessary to incorporate more complex approaches into the treatment when dealing with severely or chronically traumatized children in complex situations (Saywitz, Mannino, Berliner, & Cohen, 2000). I first give an overview of the integrative developmental model, relate recent attachment research and theory to the various coping styles of sexually abused children in interaction with their families, and then suggest treatment strategies through an illustrative case example. These treatment strategies help to disrupt these maladaptive coping styles by teaching parents and children to appropriately process feelings and ideas related to the children’s sexual abuse experiences.

**Integrated Developmental Model**

The integrated developmental model is an approach to dissociative pathology that recognizes the complex etiological roots of these symptom patterns (Silberg, 2002). There is no assumption that fragmented identity or dissociative defenses are activated at static moments of time during traumatic experiences; instead, the development of these symptom patterns is viewed as a long-term developmental process occurring within an interpersonal environment. Newer theories of self-development stress that shifting multiple self-states are normal phenomena. Theorists have stressed that dissociative patients are unable to manage the inevitable conflicts between these self-states or roles or to develop cohesive organization across state shifts (Bromberg, 1998; Putnam, 1997). The integrated developmental model stresses that it is the interpersonal environment in which the child resides that accentuates the conflicts in these self-states and impedes the development of an integrated self that could more easily process strong emotions and painful experiences. The dissociative symptoms are the manifestations of these integrative failures, so that consciousness is erratic (trance states), relevant information is discarded (forgetfulness), and conflicting, unprocessed emotions dictate behavior (fluctuations in identity or behavior).

I have speculated that children who are at risk for dissociative symptomatology have a unique composite of traits and abilities. These capacities include symbolic skills, fantasy-proneness (Rhue, Lynn, & Sandberg, 1995), empathic perceptive-ness, and social traits such as social compliance or high attachment needs that are related in part to the capacity for trance induction (Silberg, 1998). One might speculate that a child who has experienced sexual abuse from a trusted adult might be receiving conflicting messages about attachment (“You are loved by me” vs. “You are an object to me”). The child who is particularly sensitively attuned to these conflicting messages may learn a pattern of disavowal and disconnection from this conflicting information, facilitated by skill at trance-induction and ability to use fantasy for escape and coping. The sexual experiences themselves may also be trance-inducing and serve as a form of rehearsal of state-dependent learning, as the unique and specific physiological state of sexual arousal becomes associated with specific behaviors and conflicting attitudes—loving feelings and wanting to please the other, as well as helplessness and anger. This pattern of dissociation can become habitual over time in environments that discourage the resolution of these conflicting emotions. This model suggests that a full treatment approach must involve learning a new pattern of attention to internal cues so that the habit of dissociating information is replaced with attending to important emotional, cognitive, or perceptual information that will promote a more healthy adaptation. This new pattern can only occur if the environment fully supports recounting what happened, understanding what happened, and freeing the child from all of the mixed messages and symbolic meanings that the child’s behavior may have for the family.

The integrated developmental model takes very seriously the potential suggestive social influences that may affect behavior, stressed by the sociocognitive critique of dissociative identity disorder therapy (Lilienfeld et al., 1999). However, the family environment is viewed as the primary place where dissociation can be supported through family interaction styles. Parents who may view their children as “wicked,” “over-sexualized,” or “babyish” may unconsciously encourage the children to enact these fluctuating roles. Children who have been sexually abused may be even more suggestible and susceptible to this kind of environmental reinforcement. Their needs for attachment have been gratified in relationships in which they have learned to accommodate to the expectations of powerful others. They, therefore, may not have developed the in-
ternal self-regulation that healthy development requires.

To counter these environmental forces, the therapist (as presented here) encourages the development of autonomy, self-direction, and resistance to suggestion. If dissociation can be encouraged by therapist influences, as the sociocognitive model suggests, how much more invasive might it be for families to support and embellish conflicting attributions about their children in the suggestive and powerful domain of family life? Thus, the family expectations and beliefs that sustain a particular view of the child and his or her role in the family need to be understood and explored in the treatment.

Recent research suggests that children with disorganized or avoidant attachment styles might be particularly at risk for developing dissociative symptomatology (Ogawa et al., 1997). Thus, enhancing parent–child attachment patterns and communication becomes important. Family interventions involve enhancing reciprocity in communication, encouraging direct expression of feeling, and avoiding the reinforcement of regressive coping. The therapist models for the child and family interactive styles that encourage wholeness, responsibility, and tolerance for the expression of feelings.

The traumatic roots of these dysfunctional patterns are appreciated, but processing traumatic memories is not the primary goal of this treatment approach. Instead, the way that the ongoing unprocessed traumatic associations continue to affect the child’s choices and self-views is the primary emphasis in treatment. The therapy setting provides an opportunity to examine the distorted self-perceptions that have originated in the traumatic circumstances and to see how those perceptions color current behavior and reactions. For the sexually abused child, these views may include a sense of being “dirty” or “evil,” “a helpless victim,” or “loved” only for one’s sexuality or ability to give others pleasure. Examining these self-perceptions becomes important because they may precipitate dissociative withdrawal, sexualized behavior, or regressions when elicited by events or current interactions with others. The integrated developmental model emphasizes learning about the moments when the child tries to cope by use of dissociative “switches” so that the information that is being dissociated can be acknowledged, understood, and assimilated. This approach also emphasizes the environmental stressors that make a dissociative strategy adaptive for that individual and attempts to minimize these stressors in the child’s environment. For example, some families with poor tolerance for expression of angry affect may be accustomed to angry expressions only in the form of uncontrolled rage. Creating opportunities where anger can be expressed safely and in a controlled way teaches the whole family new tools for managing affect. Some families inadvertently reinforce regressive behaviors as the only way for the child to get needs met for nurturing. The family can learn to encourage more mature expressions of need and to set new family patterns.

According to Siegel (1999), who wrote about dissociative processes from a neurobiological perspective, “interpersonal processes can facilitate integration by altering the restrictive ways in which the mind may have come to organize itself” (p. 336). Thus, therapeutic intervention provides new interpersonal contexts for the child in interaction with the therapist, and in therapeutic interaction with the family, which provides incentives to develop a more coherent self. Treatment involves emphasizing self-awareness and affect regulation and encouraging the child to take responsibility for actions initially perceived as outside of his or her control. Interactions with the child emphasize acceptance of all affects, behaviors, or dissociated states and encourage self-acceptance as a first step toward self-management. Treatment is guided by normal developmental expectations and avoids iatrogenic influences that support the child or family’s belief in the literal reality of dissociated identities.

This treatment approach avoids a diagnostic orientation to assessment of dissociation in children. Childhood manifestations of dissociation do not fit into the clear-cut adult categories described in the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV; Silberg, 2000). Trying to describe children within the confines of these categorical descriptions may only constrain our understanding of the full context in which these dissociative behaviors may appear. Instead, a symptom-based approach is encouraged in assessing children and adolescents, and a treatment perspective is encouraged that addresses the individual symptoms themselves while remaining mindful to the broader meaning these symptoms may have within the child’s family. This symptom-based model of assessment is consistent with the guidelines of the International Society for the
Attachment and Dissociation

The longitudinal research of Ogawa et al. (1997) and Carlson (1998) have demonstrated a robust relationship between early infant and childhood experiences and the development of dissociative pathology into late adolescence. Those children who demonstrated disorganized and avoidant attachment styles and who experienced parental neglect were more likely to display pathological dissociation in follow-up as young adults. Liotti (1999) developed a theoretical model to explain how dissociative processes might relate to these impaired patterns of attachment. According to Liotti’s conceptual model, dissociation can best be viewed not as a defensive reaction but as a failure in integration of the normal processes of “intersubjectivity” that develop between a child and a caregiver, a failure of personal synthesis in the development of meaningful self-understanding in relation to others. Liotti hypothesized that those individuals whose caretakers are fearful and frightened may elicit multiple, competing internal working models or schemata of expectation in the caregiving relationship. Because of competing schemata, these individuals see themselves as the cause of pain to the caregiver (persecutor), the victim of harm from the caregiver (victim), or the soother and rescuer of the caregiver (rescuer). These competing schemata may be experienced simultaneously or in rapid succession, leading to confusion, impaired integration, and the “freezing” or dissociation observed in young children with disorganized attachment. Liotti further hypothesized that this impaired attachment style makes it more difficult for an individual to be able to seek comfort after a traumatic event. A feedback loop of increasing fear is created by the attempt to seek comfort while simultaneously being stymied by the unavailability of consistent comfort. Liotti emphasized that the dissociative reaction may be seen as a failure of being able to develop an organized response to the dilemma of the need for attachment and soothing, when such soothing is inconsistently available. Liotti further suggested that when the traumatic event happens within the family, the expectation of a dissociative reaction would be even more profound.

Liotti (1999) found confirmation for his theories relating disorganized attachment to dissociation by noting that the early multiple reactions of the child as persecutor, victim, and rescuer are also commonly observed dissociated roles in patients with dissociative identity disorder. Davies and Frawley (1994) have described similar constellations of countertransferral reactions elicited by dissociative patients in a therapeutic setting. Liotti noted that it is not only the child in reaction to the parent who develops these competing and disorganized roles (persecutor, victim, and rescuer) but also the frightened parent who shifts between these multiple roles, further confounding the child’s search for consistent gratification and comfort.

Families dealing with the trauma of sexual abuse of a child provide an excellent illustration of the processes by which these multiple and competing reactions on the part of the parent and the child interfere with the natural soothing and processing that allows healthy functioning to resume after trauma. Sexual abuse experiences of a child arouse so many competing feelings, desires for secrecy, memories of one’s own victimization and sexual experiences, and confused and ambivalent emotions in the child and the parent that similar processes to those described by Liotti (1999) may occur. This is likely to be the case whether the conflicting feelings are a result of abuse within the family or from maltreatment by an individual outside of the family. In either case, these competing processes lead to dissociative manifestations, forgetting, and inability to make adequate meaning out of the feelings, perceptions, and ideas stimulated by the sexual abuse.

As Liotti (1999) stated in a paraphrase of Bowlby,

Lies, deceptions, and other sources of seriously distorted family interactions force the growing child to exclude new and potentially meaningful information, already stored in the implicit or in the episodic memory system, from communication, and therefore from semantic processing and from conscious thought. (p. 307)

Families dealing with sexual abuse can easily establish an environment in which deception and distortions interfere with the integration of information required for healthy, integrated development.

In a fascinating and perceptive article by Maker and Buttenheim (2000), the authors described how parenting difficulties can emerge among sexual abuse survivors when trying to deal with normal parenting responsibilities in
which issues of aggression, sexuality, and limi-
ting will naturally emerge. In their case de-
scription, they show how a mother’s sexual abuse
history led her to engage in multiple and vacil-
lating roles with her child. She alternately over-
idified with the child as victim, saw him as a
perpetrator, and became flooded with memories
of her own shame, guilt, and responsibility to
rescue him. These fluctuating pulls rendered her
helpless to intervene effectively as a parent. The
authors’ treatment approach involved parenting
education and role plays to break the cycles of
reenactment, gradually increasing the mother’s
competence and belief in her own parenting suc-
cess and helping her diffuse and process the in-
tense anxiety about her own history that the
child’s behavior aroused.

Children who have been sexually abused acti-
vate similar dynamics in their parents whether the
parents have or have not been victims of sexual
abuse themselves. The issues aroused are com-
plex and personal and stimulate any distorted self-views and feelings of inadequacy harbored
by parents. In my experience, working with par-
ents to help them come to terms with their own
responses to the sexual abuse experiences of the
child is necessary for healing. This process inter-
rupts the dissociative reactions that emerge in
parent–child interactions that become rigid recipro-
cal enactments of the worst fears and beliefs of
parent and child about who they are and what
they can expect in relationships. Careful exami-
nation of some of these family dynamics partly
substantiates Liotti’s (1999) theories about the
competing and multiple reciprocal roles that par-
ents and children may display following trauma
that prevent restorative soothing. As illustrated
later in this article, these multiple and competing
parental views of self and child both lead to and
sustain dissociative processes in these families.

The following case study explores how the in-
ternal working models described by Liotti (1999)
as the basis for disorganized attachment and dis-
sociation in infancy can also characterize parental
responses to the sexually abused child. The re-
sulting interactive pattern leads to an environ-
ment that fuels dissociative adaptations in a child
struggling to make meaning out of the experi-
ences of abuse while also grappling with the con-
fusing and conflicting reactions of the caregiver.
Parents identify with the child as a victim while
feeling victimized themselves by their child.
They may also identify with the abuser and blame
the child for behavior that is a consequence of
sexual abuse or, alternatively, may overly iden-
tify with the need to rescue the child or be res-
cued by the child. All of these stances interfere
with the child’s ability to make meaning out of
the experience of sexual abuse, integrate it, and
move on.

Case of Betsy

Betsy, age 11, was referred for treatment for
“sexual offending” behavior toward girls her age
and younger. When her father had become vio-
 lent toward her mother after 6 months of mar-
riage, her mother separated from him. Following
a court-ordered visitation with her father at age
2½, Betsy stated that “Daddy touches and licks
my Suzie.”

Despite repeated protective service reports and
court hearings over the next several years, visi-
tations continued. At age 6, Betsy described par-
ties at her father’s house during which many men
would sexually abuse her. Now more articulate,
Betsy was able to provide graphic details that
finally led to substantiation of her report by the
state child services department. The judge who
had been hearing the case had retired. The new
judge reversed the court’s previous findings, halt-
ing visitation with the father. Betsy’s father
agreed to terminate parental rights in return for
assurance that no criminal charges would be
filed.

Although Betsy received therapy over the next
several years, her problems began to escalate at
age 11. She became fearful of attending her new
middle school and had great difficulty getting up
in the morning, entering trance-like states lasting
up to 2 hr in which she was unresponsive to her
mother. She also reported hearing voices in her
head that ordered her to make sexual advances
toward other children. The trance-like states and
voices suggested the presence of dissociative
processes.

A symptom-based assessment approach sug-
gested that immediate intervention was required
in the areas of school refusal and sexual acting
out. Careful analysis helped elucidate many lev-
els of feelings that contributed to these behaviors.
Betsy stated that when her mother yelled at her to
get ready in the morning, it reminded her of the
years of forced visitation. She reported that she
heard voices in her head yelling at her not to go
and not to listen to her mother. She explained that

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she would silence these voices by tuning them out and becoming “out of it.”

Betsy was asked to attend more carefully to what these voices were telling her. She identified one that told her to comply because her mother was right, one that urged her to hit and defy her mother, and a childlike voice that said she was too young to go to school. These three voices correspond to the three relationship orientations described by Liotti (1999) as underlying attachment conflicts of dissociative patients: victim, victimizer, and rescuer. To interrupt the “shutdown” resulting from these competing working models and strengthen the attachment relationship, the therapist encouraged Betsy to communicate each of these conflicting perspectives to her mother, allowing her mother to hear and respond to her daughter’s concerns.

Next, a careful analysis was conducted of Betsy’s mother’s reactions to these events. Mother stated that she was furious at Betsy for not going to school and for making her late for work, complaining that she felt helpless when Betsy entered trance states. These encounters reminded her of her helplessness when the court ordered her to let Betsy visit her father even though she knew she was being abused. She expressed overwhelming guilt about letting her daughter down and a strong need to rescue and soothe her, which inhibited her from being firm about school attendance. These conflicting impulses suggest that Betsy’s mother also experienced all three stances described by Liotti (1999): a desire to punish for not doing the right thing (victimizer), a feeling of helplessness and immobilization (victim), and a pull to protect (rescuer).

Therapy provided the opportunity for these conflicting attitudes to be expressed. During a family session, Betsy’s mother was encouraged to remember times when she was forced to send Betsy to her father and how powerless and angry Betsy must have felt. Although this was very difficult for her, she was encouraged to empathize with the rage and helplessness her daughter felt at those moments. She was asked to listen to Betsy’s description of these feelings and to see “the little 5 year old” in Betsy that so much wanted a “mommy” to keep her safe. Betsy responded by sobbing deeply; her mother was asked to simply tolerate this, hug her, and let her cry as she experienced these painful feelings. In allowing this expression, Betsy’s mother provided the kind of soothing comfort that she was not able to supply in the past.

Betsy was also encouraged to express her anger at her mother for restricting her from social events at school due to her mother’s fears that Betsy would victimize others. Betsy’s mother was prompted to listen to Betsy’s complaints. The two of them negotiated how Betsy could ensure that she would not endanger others while attending these activities.

In order to avoid having Betsy’s mother burden Betsy with her own overwhelming feelings about past events, the therapist addressed these feelings in individual sessions. These sessions provided Betsy’s mother with a forum to safely express her own rage and frustration at what had happened to her and her daughter. The opportunity to sort out and come to terms with her own feelings helped her avoid reacting to Betsy’s hesitancy to attend school in a manner that had contributed to Betsy’s “shutdown” response, fortifying the attachment relationship.

As Betsy learned to express her conflicting feelings to her mother, she no longer heard the battling voices in her mind. As a behavioral intervention for the morning trance states, Betsy’s mother was told to simply ask her once to go to school and then to monitor the length of time it took for Betsy to come out of the trance by herself. This approach placed Betsy in charge of her own behavior and diffused her mother’s frantic sense of helplessness. Betsy’s mother was taught how to set up a reward system for school attendance and punctuality. Contact with the school explaining the intervention secured their cooperation; Betsy was freely given late passes during her initial week back at school as she was adjusting to regular attendance. In response to these simple interventions, Betsy was attending school on time within 1 ½ weeks.

Nevertheless, Betsy still reported hearing a voice in her mind that told her to do sexual things to others. With encouragement to listen more carefully to this voice, she reported that it was conveying that this was the way to get close to people and keep them from abandoning her. These meanings of sexual behavior were related to the momentary relief from her father’s violence that she experienced during sexual molestation by him. By identifying these feelings, Betsy was able to articulate other ways to manage her need for closeness and fear of abandonment by friends. She learned to recognize when these
feelings arose and to find outlets for them other than sexualized behavior.

Emphasis was placed on education about sexual matters, an important component of treatment for sexually abused children (Wieland, 1998). Betsy was told that rather than reject her sexuality as “bad,” she should learn to value this part of herself to which she had been introduced by her father “way too young.” As she explored these feelings, she no longer heard the voice talking to her and increasingly experienced these behaviors as being under her own control.

It became clear that Betsy’s mother’s characterization of Betsy as a “sexual offender” implied that Betsy was destined to become like her father. By rejecting Betsy and her behavior, she temporarily alleviated her own guilt about the visitations during which Betsy had been abused. Reframing Betsy’s sexual behavior as being motivated by a desire to obtain closeness and avoid abandonment helped Betsy’s mother view it in a less pejorative way. Open communication between Betsy and her mother about sexual matters helped reduce the dissociation that had been fostered by treating sexuality as shameful and secretive. They were able to establish an agreement that Betsy would go to her mother when she felt sexual impulses toward other children, so that increased closeness with her mother could alleviate her lonely feelings and fears.

As treatment progressed, Betsy began to have posttraumatic nightmares in which she relived some of the instances of sexual abuse in her father’s house. Initially, she recorded these dreams and memories in a notebook, but in therapy she was encouraged to add commentaries on what she might do now or how she could now see these events differently. Dealing with the memories in this way emphasized coping and mastery, helping Betsy overcome the fear and horror she had previously experienced. Eventually, as feelings about the unfairness that her father had never been punished began to surface, she and her mother were encouraged to share their rage about this without taking it out on each other. When inevitable fights occurred between the two of them, they were taught how to give each other space, sort out conflicting feelings separately, and seek help as needed from therapists. After 10 months of treatment, all dissociative behaviors, school refusal, and sexual acting out had ceased as intense scenarios that activated old feelings were defused and the family learned to communicate more effectively.

Clinical Implications

Conceptual Implications

The case of Betsy illustrates several important points about sexually abused children who exhibit dissociative symptoms. This vignette shows how issues of sexual abuse raise excruciatingly intense feelings in families. When unexpressed, these feelings are enacted in subtle ways that can set the stage for the development of a dissociative response style in the abused child. While the sexual abuse experiences themselves may foster dissociation, the subsequent fall-out created by the way the family reacts to these events can further contribute to dissociative symptom formation.

These are complex cases that require appreciation of the entire context in which the abuse occurred. The memories of the sexual abuse events themselves almost pale in comparison to other parent–child issues that emerge in processing an account as painful as Betsy’s and her mother’s. Dissociation in cases such as this can be understood as an activation of intense attachment conflicts from which neither mother nor child knew how to extricate themselves. Conflicted and powerful affect that each experienced triggered the other into equally intense and countervailing feelings. These feedback cycles promote dissociative shutdown that may be reminiscent for the child of earlier traumatic times when he or she would retreat into a trance-like state. In Betsy’s case, the traumatic events of the sexual abuse and the forced separation from her mother triggered her dissociative response style.

Treatment Implications

Dissociation in children is usually promoted by a dyadic relationship in which multiple competing models of self and other are in conflict. Unraveling these conflicts requires a careful combination of family and individual symptom-based approaches. When meaningful information about past and current feelings is communicated, an atmosphere is created that counteracts dissociative shutdown and fragmentation. A symptomatic approach to Betsy’s sexual acting out and school avoidance, for example, led to clarification of the feelings behind these difficulties. This, in turn, allowed these feelings to be communicated and
ultimately allowed Betsy to obtain the soothing she was seeking. In contrast, a more simplistic conceptualization might have exclusively viewed Betsy’s dissociation as having been rigidly fixed during the traumatic events. Such an approach might have missed the subtle interpersonal factors in the family that reinforced and maintained the dissociative coping behaviors.

To address these various contributors to dissociative responding, one needs a comprehensive treatment perspective that includes three major foci: (a) addressing symptoms directly, (b) conceptualizing symptomatic behaviors as expressions of unstated contradictory pulls and feelings within the child and in the family system, and (c) promoting communication so that family members can come to terms with the painful secretive feelings they harbor about the meaning of having a child who has been sexually abused. Failure to confront these real and complex issues places the children at risk for resorting to expressing confused feelings through dissociative states or identity fragments. While dealing with the traumatic material itself is a desensitizing and empowering component of the treatment, in these complex cases in which dissociative processes are evident, the layers of dissociated feelings and attitudes among the parents must also be confronted and expressed.

Sociopolitical Implications

In the aftermath of the sexual abuse of a child, one of the factors that families must confront is the disturbing reality that it is very difficult to get a conviction for sexual offenses against children. This scenario challenges these families, for it means that on one level they are coping with society’s dissociation of the harm that some will do to children. Why should Betsy and her mother, on top of everything else they have to come to terms with, have to face that the men who hurt her will never be held responsible for the damage they have done?

Through their symptoms, children display the conflicts and contradictions inherent in the unsafe world around them. In situations such as Betsy’s, children may express their rage at the betrayal and lack of safety and protection they experience through disowned parts of the self. On one level, in its ambivalent and contradictory approach to providing safety and nurturing to its own children, our society may be seen as fostering the “disorganized” attachment described by Liotti (1999).

References


Parenting the Dissociative Child

Over the last ten years my practice has been devoted to the evaluation and treatment of children with severe dissociative disorders. These children come from every social class, race, and family circumstance. Some have been adopted or placed in foster families after years of cruel and sadistic treatment from their original families. Some are living with original families and were abused by babysitters, “friends” of the family or extended family members. Others have congenital birth defects or illnesses and have required repeated and painful medical procedures to ensure their survival. Some have experienced stressful life circumstances of a milder nature, including personal losses, parental conflicts, or disappointments in school. Others have observed interpersonal violence in their neighborhoods or homes. Whatever the source for the particular child, I have found that it is always important to work with the families to help them provide the child hope and optimism, loving protection, and the structure of increasingly challenging expectations within the framework of empathy and understanding. All of this may be easier said than done, but I have found that the vast majority of families that I work with are quick to understand on an intuitive level what the child most needs, and are able to provide the kind of environments that can be healing. My research shows that the consistent availability of at least one parent during the course of treatment is the best predictor of a successful outcome for a dissociative child (Silberg & Waters, 1998).

The first thing parents want to know is how much they should interact or develop relationships with the different alters, or the separate aspects of the self. During the early parts of treatment, I find that it is very important that the parent make some kind of connection with those parts of the child that they have not known about before. However, this can be done very subtly. I ask the parents, for example, when hugging the child, to gently whisper in the child’s ear “Remember, I am hugging all of you.” It is important that the child perceive that the parent truly accepts the child in his/her entirety. Sometimes I ask the parents to write letters to the child that express appreciation for the whole self. For example, a parent might write “I love how well you protect yourself when you are mad, I love the part of you that can be so cuddly, I love how independent you can be…” In this way the parent can make a connection with all of the fragmented parts and can reframe all of them in positive ways. With children who are adopted, I find that sometimes there are parts of the child that do not feel they have been adopted. In these cases sometimes we will have an adoption ceremony in the therapy in which a doll might be used to represent part of the self, and I have the parents affirm her/his love to this part of the child as well.

Adoption rituals can only go so far, however. It is important that the parent behavior also reflect in day-to-day interactions that the “whole self” is loved. Sometimes parents make minimizing comments that are demeaning to the child such as “Where’s that good little boy I know is there?” which can invalidate the child’s feelings and again encourage dissociation. One child I worked with taught me the meaning of the “blood pressure cuff” which I often use with families of dissociative children. This child was afraid of blood pressure cuffs, and we finally traced this fear to a story in an emergency room, where the child was terrified and the nurse was putting on a blood pressure cuff that was automatic. The more the child resisted in fear, the tighter the cuff became. This became a metaphor for the child of all experiences in which her genuine attempts to escape from fearful intrusions or to express her real feelings were met with worse intrusion. It became clear that the child perceived her mother as “blood pressure cuffs” on certain occasions, particularly when she was angry about something her mother had done, and she got punished for expressing her anger. I teach parents to notice when they are being “blood pressure cuffs,” and let children have an opportunity to express their real feelings, even rage, safely without punishment or consequence. Parents need to learn to make the important distinction between a feeling and a behavior, and allow free expression of the feelings that are often very intense with dissociative children, particularly in the early stages of their treatment. The parents’ ability to validate the children’s feelings without being defensive or punishing is the biggest key to success in helping dissociative children heal. For example the child might shout in anger, “I hate you when you do that.” This is time for the parent to quietly listen to what is upsetting the child, not to correct the child.

I do not encourage parents to have direct relationships with different parts of the self or to call them by other names. Instead they can refer to them by descriptors—that part of you that gets so angry, or that part of you that likes a lot of attention, and acts so young. This is more normalizing to the child. I never encourage the parents to purchase separate items for the different aspects of the child as this can breed competitiveness among the parts and produce more fragmentation and dissociation.

Parents need to learn to help the child access the appropriate states at
the appropriate times. Sometimes families have developed code words that help serve as reminders to the child to have a more mature state present during homework time, for example. The simple phrase “It’s time to get it together” can serve this function well (Waters, 1999b). Bedtime is the best time for younger parts of the self to emerge as it is common for children to regress at bedtime and want cuddling and story telling. Normal children will often regress at bedtime. I tell the child that whatever part of the self presents, they must learn to experience their life with their whole self at all times. This is easier for dissociative children than adults, and they do readily learn to dissolve the barriers with gentle encouragement and practice in therapy.

Some parents feel concerned about setting limits on children for destructive behavior or aggression when the children seem to have really forgotten what they did. Parents should not fall into this trap. Dissociative children need firm limits and even though they may feel sometimes that they are punished for something they did not do, this serves as a learning experience which will ultimately lead to the co-consciousness or full memory that they need. The child can be instructed to discuss the unfairness with their therapist who might provide the environment that will allow the child to remember the behavior that is not acknowledged. However, I do not encourage punishing children for expressing anger, for using curse words, or even for throwing things, if it is done safely with soft objects. Frank destruction of other’s property or hurting other people should receive a consequence.

Some adolescents that I treat have not told their parents about their dissociative fragmentation and prefer to keep this private. If I judge this to be safe for the child and family, I often go along with this, and explain to parents in a general way that the teenager has difficulty with mood control, and that I will be helping the teen learn to manage this more effectively. This seems to work alright and discourages the playing of the “sick role” which can severely prolong the treatment of some teens.

It is important for parents to respect the child’s pace in dealing with the traumatic memories of their past. Some children do not want to get deeply into this, and it is not the parents’ place to push or force the child to explore things they are not ready to. On the other hand, sometimes, particularly at bedtime, children may want to talk about a fresh memory they just recalled, and it is good if parents can provide an empathic ear at that time. Some children like the opportunity to write things down at bedtime in a journal. There is no right pace or amount of traumatic work that any child should do. The therapist and parent should respect the child’s choice here. Clearly if the child is experiencing repeated flashbacks and is flooded with a painful memory, it is an important time to intervene therapeutically to stop that process. I have found that at those times, when more traumatic material emerges, there is always some current stress in the child’s life that has stimulated it and maintained it and this is important to investigate and understand completely.

It is easy for the dissociative disorder or the child’s past to become a distraction from the real job of childhood, which is to learn, grow, and to play in a safe and loving environment. The parent should protect any and all opportunities that the child has to accomplish these goals, and see that the child’s unfortunate life experiences do not lead to an overemphasis on what is “wrong” rather than what is “right.” I encourage my patients to get involved in hobbies—sports, music, horsebackriding or other extracurricular activities. Parents need to provide the kind of expectations that will encourage growth, keeping in mind that special accommodations will need to be made for the intensity of feelings that the child will display. When scared, the child may get very panicky, but they can learn to modulate this. When angry, the child may feel rage that has been stored up for a long time, but if accepted, this rage will lessen over time. At times, the child may be overwhelmed with sadness, but in time children can learn techniques for restoring themselves to a more even mood. It is important that the parents not overly personalize when the child is expressing intense emotions but see this as the child’s adaptive emotional system getting turned on to work properly and welcome this as signs of growth and correction.

Dissociative children in treatment should be getting better. If things are getting worse, it is important to look at whether the family is resistant to the kind of changes that are important for the child’s growth, or whether the child is trying to communicate that he/she is still not safe. Family therapy may be needed.

If the child continues to do worse rather than better during treatment, get another opinion. Childhood is too precious. All children deserve a time when they can grow and enjoy the simple pleasures of life.
Parents as Partners in the Treatment of Dissociative Children

Frances S. Waters

Effective treatment of the traumatized dissociative child includes engaging the child's family to facilitate the child's ongoing recovery from trauma. As demonstrated repeatedly (Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Silberg & Waters, Chapter 6, this volume), dissociative children who make the most gains from appropriate therapy are the ones in a safe and nurturing environment with consistent parents. Consistent parenting promotes healthy attachment, provides affect modulation and containment, and helps to counteract the pessimism and demoralization learned from the child's abusive experiences. Providing the ideal environment for dissociative children is a challenge, as their behavior may be provocative, rejecting, and out of control. Many parents report that these children may seem uncaring or unattached, and parents are embarrassed by their child or adolescent's unpredictable behavior. Families are hungry for any clues that might help them understand, manage, and normalize their child's behavior. The therapist's task is to stimulate parental involvement in treatment and to provide guidance and support to parents in their difficult role. Therapists need to spend considerable time with parents of dissociative children, particularly in the initial stage of treatment, to engage them as collaborators and supporters of their child's therapy. Parents need to be viewed as the "in home treatment providers" of their child since they are more likely to be present when he/she abreacts traumatic memories, has nightmares, switches personalities, and has extreme mood changes. This chapter presents a review of the parenting challenges these children present, suggestions for thera-
peutic approaches to parents, and some behavior management strategies appropriate for families with dissociative children and adolescents.
In my experience, most families I have encountered are cooperative, engaged, and eager for direction and support. However, the traumatic background of these at-risk children dictates that the first task with families is always to assess if the child is safe. Severely pathological environments of dissociative children characterized by abuse, neglect, and conflicting demands have been described by Dell and Eisenhower (1990), Fagan and McMahon (1984), and Kluft (1986). Krugman (1987) has described an intergenerational pattern of family violence characterized by impairment of attachment, in which child maltreatment reflects ongoing environmental stressors and parental frustrations. In cases of extreme family pathology and child endangerment, involvement of protective service agencies is essential. The setting of firm, carefully enforced limits with abusers and refusal to collude with a family presentation of "face-saving falsehoods" are essential strategies (Kluft, 1986). Krugman (1987) emphasizes interventions for abusive families within a multi-modal, coordinated treatment plan that addresses the full ecological system. In these cases, addressing the dissociative aspects of the child’s pathology in therapy is ill-advised, as the child retains the need for these defenses as long as danger is perceived.

Fagan and McMahon (1984) advise that the assessment of the family environment should include both the family’s willingness to cooperate with treatment recommendations and the severity of the child’s acting-out potential. Dissociative children can be extremely provocative with angry alters or pseudo-mature adult alters who test parental authority. They can exhibit sudden destructive or challenging behaviors that place intense demands on parents and require them to exercise self-control and employ appropriate child management techniques. If these parents have unresolved trauma issues themselves, the child is at high risk for re-traumatization. Given this precarious atmosphere, it is imperative that the parents’ mental health status and child’s safety be continually evaluated, particularly if the child is residing in the family of origin of the trauma. However, the therapist should not disregard the need to assess these issues in foster homes or adoptive homes as well. While I have worked with numerous stable and committed placement homes, one of my DID patients was sexually abused by her adoptive father shortly after placement, and others have experienced other forms of retraumatization.

In order for the therapist to take a firm stance in being the child’s strongest advocate and manage the treatment process of a child at risk, the therapist should collaborate with the criminal justice system and its personnel, the school environment, protective service agencies, health personnel, and placement agencies. If available in the community, the therapist might join an interdisciplinary team of professionals specializing in facets of child abuse. This team can assist in crisis management and long term monitoring of abusive families. Effective child treatment in these cases must synchronize interdisciplinary efforts on behalf of the child.
I have found a straightforward approach in working with abusive families to be effective. Limits are set with expressed sincerity, understanding, and empathy to chaotic families, who are desperate for relief. A detailed family genealogy that tracks abuse history, substance abuse history, and mental illness can suggest problematic areas in the family constellation that may influence the child’s recovery and course of treatment. Appropriate referral of family members who have a history of emotional, physical, or sexual abuse or substance abuse problems may avert a crisis from occurring, e.g., further maltreatment of the child or mental deterioration of a parent which requires hospitalization and placement of the child.

The techniques and recommendations described in the remainder of this chapter are most appropriate when working with families that are not abusive or in severe turmoil. These are families that may have crises, temporary disruptions, or lapses in judgment, but these families are characterized by stability, commitment, and availability to the child during recovery.

The Challenges of the Dissociative Child

Traumatized children have multiple deficits in cognition, affect, interpersonal relationships, impulse control, and vegetative function (Eth & Pynoos, 1985). These deficits may impede their learning and adjustment to family routines. Dissociative children present other unique challenges which further compound these trauma-based developmental problems. A dissociative child is amnestic periodically to intense and sudden behaviors and feelings, exhibits varied developmental needs due to alters’ different ages, and has sudden flashbacks of traumatic memories (Hornstein & Tyson, 1991). These dissociative features complicate the parenting of the child and place considerable strain on the parents and other family members to manage the child effectively and intervene appropriately.

When a dissociative child lives in a family with siblings, parents have the added burden of deciding when to intercede to protect younger siblings from harm and when to allow the siblings to resolve what appears to be a normal squabble. Parents need to be vigilant to step in quickly and effectively to prevent the dissociative child or other family members from being hurt by alters who may contain anger or hatred and express homicidal or suicidal feelings. Minor irritations with a sibling, e.g., conflict over a toy, could result in the sibling becoming seriously harmed by an alter who spontaneously emerges. One mother reported that her 2-year-old son enjoyed singing at the breakfast table but her 9-year-old dissociative daughter became very angry at her brother’s singing and lashed out at him repeatedly. The mother had to arrange for the two children to eat their breakfast at separate locations to prevent further harm to her 2-year-old.
Many parents of children who were diagnosed with a DID (Dissociative Identity Disorder) have described a typical scenario at a family gathering. The mother turns her back when her children are playing satisfactorily. Her dissociative child, Johnny, suddenly picks up a stick and swings it at his younger sister, who begins to wail. Johnny’s mother intervenes to reprimand him. Johnny appears perplexed about what happened and adamantly denies he is responsible. Upon further exploration with Johnny by his therapist, it is learned that his angry alter had emerged momentarily to hit his sister; Johnny himself was amnestic to this event.

These incidents are very challenging for the parent who may feel that normal parental interventions, such as grounding or taking away privileges, are ineffective in preventing further incidents from occurring. The usual parenting strategy of grounding both siblings until the responsible party admits to the incident may not be effective. A dissociative child who is amnestic to his behavior may not be able to admit to his behavior unless he has co-consciousness and awareness of his alter’s offending behavior. My experience with dissociative children indicates that while behavioral interventions need to be in place, they have minimal impact on the child’s ability to control himself and learn from the consequences. Effective therapeutic approaches (as described in Chapter 8) will ultimately enable the child to control his destructive impulses and benefit from appropriate child management techniques.

There are many other trying incidents parents of dissociative children have to face. A parent may be called from work or home to pick up the child at school for an unprovoked attack on a child or teacher. At other times, the school will call to report that the child is dazed or unresponsive. The child’s shifting academic profile makes scholastic planning difficult, and some settings may not be willing to keep the child in the school program.

The everyday routines of eating, dressing and sleeping may become battlegrounds as alters vie for control, display changing preferences, or experience traumatic triggers. Dinner may be interrupted because the dissociative child switches alter states and refuses to eat what is prepared because the alter does not like the meal. One parent of an 8-year old DID girl reported to me how she had to be constantly aware as to what alter was present in the morning and to adjust her schedule and developmental expectations of her child accordingly. Mornings were often slow periods, in which decisions made the previous night as to what the child wanted to wear were changed in the morning if another alter who had a different preference was dominant. If a younger alter was out, then the mother would have to assist her in picking out the appropriate school clothes. Also, this younger alter would easily get sidetracked and require more supervision and direction to brush her teeth and hair. A parent may be awakened during the night to attend to a child who is abreacting a traumatic memory. A tired parent watching their child "relive" abusive
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episodes may become confused, frightened, or impatient. These daily challenges require the parents to be adaptable and tolerant.

Oftentimes parents of an undiagnosed dissociative child are, at best, perplexed by their child’s denial of unacceptable behavior or repetitive destructive behavior. Their child appears sincere, confused, and angry at being unfairly accused. Parents wonder if their child is lying to manipulate the situation or to blame others to avoid consequences. The parents are angry and exhausted by their child’s frequent outburst of unprovoked, assaulting, and destructive behavior. These parents may even think that they are “losing their minds” when they observe their dissociative child act out and the child totally denies what they had witnessed.

These are some of the daily challenges facing parents of dissociative children. However, as challenging as these children are, they need a safe and supportive family environment with parents who have stamina and stability. If at all possible, it is important to maintain the child in a home environment and provide the child with the opportunity to have consistent nurturing and understanding from capable parents, siblings, and extended family members. It is imperative that therapist work closely with parents and provide them with guidelines to assist them in understanding and managing these provocative children.

These tasks and guidelines are derived from working with parents and care providers of approximately 50 dissociative children (dissociative identity disorder and dissociative disorder not otherwise specified) from my clinical practice and from consultation with other therapists treating dissociative children (Hornstein & Waters, 1995; Silberg & Waters, 1995; Waterbury & Waters, 1992).

Therapeutic Strategies for Parents

The challenges discussed above may seriously strain the parents’ marriage or the child’s sibling relationships. The child’s continued placement in school may be in jeopardy, and issues related to protective service reports may result in further intrusions and disruption to the family. The therapist who works closely with the family can provide support during these difficult times, guidance in decision-making, and advocacy for the child. In this team approach, the parent provides weekly feedback to the therapist regarding the child’s behavior at home, at school, and in the community, and the therapist informs the parent of the progress of his child’s therapy. Usually I see the parent briefly at the beginning of the scheduled child’s session. Confidentiality with the child is respected, but I may request permission from the child to inform the parent about the child’s dissociative states, traumatic incidents, or feelings and thoughts, as these may help the parent achieve an ongoing understanding of their child’s behavior. Preferably I will have supportive and understanding par-
ents join the sessions as the child tells them about his/her alters, trauma, feelings, and thoughts throughout the course of treatment. During particularly difficult times for the parents, they may require a session devoted to only them as tactical management approaches are planned together.

Below are concrete therapeutic strategies designed to help parents accomplish the goal of successfully maintaining their child at home and supporting the child's treatment. These approaches may apply to biological, adoptive, or foster parents.

1. Educate the parents about the child's dissociation.

Education is a most important task which occurs throughout the treatment process. Providing parents with the knowledge of trauma and its impact, information about the dynamics of dissociation, and the stages of treatment will assist the parents in knowing what to expect and enable them to become a part of the treatment team. At each stage of treatment the parents will need to know obstacles which they may encounter and become prepared to deal with them. The parents will need to know how to respond to the particular issues during the treatment stages, and how to provide the necessary adjustments in their home to manage the child's intense feelings, thought, and behaviors as traumatic memories are surfacing. Providing written materials about dissociation will aid the parents in learning about the dynamics related to dissociation and the process of treatment (see Appendix B).

2. Explain to the parents about the importance of structure and predictability when managing the dissociative child.

Children who have suffered traumatic events that were sudden, unpredictable, or frequent may become accustomed to using dissociative defenses. This learned coping style may be used in mildly stressful circumstances as well. One 8-year-old DID patient would "blank out" (dissociate) when a stranger to the child—but friend to the parents—would come to the house. These children have conditioned themselves to dissociate because of their distrust of adults and their environment and their fragile personality makeup. Dissociation has become a conditioned and routine response to minor stresses. Providing predictability and structure may help to defeat this conditioned response.

While it is impossible to provide constant structure and predictability in a family's life, the parents need to be aware that any simple change in the schedule may cause a switch in the personality of the child or the
child may become easily agitated. Knowing this, parents may prevent these events from escalating by discussing in advance any anticipated changes in the schedule. When there has been an unanticipated change in the schedule, it is wise to explain to the child the situation and ask him or her (and the alters, if known) for their cooperation. This can be an opportunity for the parent to educate the child about learning to trust in changes and that changes in the family schedule do not mean harm to the child.

Structure and predictability can also help to manage the sometimes embarrassing appearance of an alter. For example, the therapist may help the family contract with the child to allow a baby alter to come out at bath time or bedtime to avoid appearing in school. Many dissociative children have an alter of the opposite sex. Providing toys, such as trucks desired by a male alter of a female child, seems to negate gender-based resentment and competition over activities. Although some professionals have expressed fears that this could result in more separation of the personality, I have found that allowing alters to get their needs met at appropriate times actually erodes boundaries and sets the stage for successful integration.

However, as a cautionary note, parents need to be judicious in eliciting alters for special occasions or special treats or catering to an alter’s wants and desires. Such treatment can cause jealousy and internal power conflicts. The child’s whole personality system needs to be the focal point and it may not be advantageous to obtain special gifts. Parents and therapist should discuss this issue and carefully decide to what degree the parent should meet a specific request by an alter, using the guiding rule, How might it benefit the child’s total personality system, and the child’s over-all recovery? The therapist and parents should also discuss the appropriateness of a parent’s initiating communication with a specific alter. In my clinical cases, a parent might call for a particular alter related to an explicit behavior problem or request assistance from an alter to solve a problem. Additionally, alters spontaneously emerge at home to work on traumatic memories with the parent and to receive attention to deal with developmental needs.

The child, therapist, and parents should discuss the issues of time, activities, toys, food and clothing preferences, and negotiate with the alters over such matters respecting time constraints and limited resources. In most cases, increasing the child’s awareness that toys are common possessions is better than a toy belonging to one alter. If the therapist is constantly working towards co-consciousness and sharing of experience, all parts of the personality will enjoy the special moments that have been prearranged for a designated alter to emerge. Kluft (1985a) and McMahon and Fagan (1993) have also described this outcome. A general rule for alters’ appearance is that they occur in the home, and after the child has completed homework.
3. Explain to the parents about the importance of establishing and maintaining family rituals.

Many of my dissociative patients have reported that they were abused in a ritualistic manner and during holidays or birthdays. Ritual abuse is defined by Bryant, Kessler, and Shirar (1992) as "... any kind of abuse done in a ceremonial or systematic form by a specific group." The report of the Ritual Abuse Task Force of the Los Angeles County Commission for Women (1994) gives some reported examples of ritual abuse (psychological abuse, physical abuse, and sexual abuse) which describe the scope of brutality a child may have endured.

Parents need to be aware that children can have anniversary reactions to trauma on those holidays, birthdays, or special events for years after the original traumatic event. These anniversary reactions may include post-traumatic nightmares, recurring and intrusive memories, and thoughts and feelings associated with the trauma. In order for parents to be prepared for those anniversary times, the therapist and parents should discuss the rituals associated with the abuse and the special times or dates when the trauma occurred. Parents are much better at coping with and adapting to a child's flashbacks to a traumatic event if they expect it and prepare for it. The parents are advised how to respond to the child's reactions and establish new rituals on anniversary dates.

In family therapy session therapist and parents discuss with the child in advance the forthcoming anniversary memory and assist the child to process it cognitively, emotionally, and spiritually. They work out a plan of how that day can be structured differently. The child can have input as to what he would like to do on that day to make the memory for the next year overshadow the memory of the original traumatic event. Much open discussion about the details of the day, even what the menu will be for the event, is frequently repeated. In preparation of the day, the parents, child, and therapist develop techniques to be employed at home for the child to deal with the intense feelings toward the abuser which may surface. (Any of the modified treatment techniques described under #7, Child Management Guidelines, page 291, may be useful.) Preparation for anniversary reactions is the key to minimizing the negative influence of the original trauma.

Due to dissociative children's sensitivity and vulnerability to simple changes, it is wise to repeat family rituals yearly if feasible. One highly anxious 10-year-old DID patient requested that the same 4-course Christmas dinner be served each year, as she feared dissociating if there were any variations in the menu.

**Bedtime Rituals.** Traumatized children have reported being sexually abused in bed or at bedtime and will frequently have sleep disorders. They will resist going to sleep because bedtime is a reminder of the trauma, or
they will fear recurring nightmares. An exhausted 5-year-old DID girl would literally hold her eyelids open to keep herself from falling asleep because she had been abused at bedtime and had terrifying nightmares. To minimize anxieties about bedtime, the parent should set a routine bedtime ritual in which the child and parent spend rewarding time together.

It is best to discuss traumatic memories earlier in the evening, if possible. One set of adoptive parents would set a 7:00 p.m. time for such discussions, which allowed the child to deal with disturbing feelings earlier in the evening and be calmer at bedtime. This helped her to go to sleep on a positive note. Parents need to frequently remind and encourage their dissociative child to discuss feelings and memories at the prearranged time.

Even if an earlier time was arranged for discussion of feelings, it is common for children to have memories surface as they climb into bed. Therefore, parents need to be alert to such occurrences and set an early time for bedtime preparation in the event that their child needs to talk before it is late, and the parents are too exhausted.

Reading children’s books in the early evening which deal with values or conflict resolution can help the child discuss issues relevant to him- or herself (see Appendix B). The Berenstain Bears Series (1987) contains excellent examples of universal conflicts with which families struggle and can open a discussion for the child and parents. Storytelling by the parents with the theme of a child or animal overcoming some struggle that parallels the child’s difficulties can be therapeutic for the child. With young children, parents can hold and rock the child at bedtime. Although traumatized children may have difficulty with receiving or giving hugs, parents can offer hugs but respect their child’s limits. Parents need to make references to hugging and loving all those parts of the child. From my clinical experience, this actually encourages cooperation and co-consciousness among the alters and decreases jealousy within the personality system. Parents need to reassure their child that they care for him or her and are there to help. Ending the night with a positive talk with the child about his or her qualities and something good the child did that day can overshadow a difficult day and encourage positive reframing of the child’s negative self-perception.

I have made tapes for dissociative children to listen to at bedtime that can contain a "safe place" for the child (see Chapter 8), messages about cooperation and co-consciousness within the personality system, cooperation with the child’s family, and soothing symbols and metaphors designed to encourage sleep.

4. Discuss homework and academic concerns and set realistic goals.

Frequently parents’ greatest struggle with their child is assisting the child with homework. Until the personality system is known and there is
internal cooperation, the child may not be able to consistently complete assignments and turn the homework in on time. This concern brings up important questions which the parent needs to address. What should the school know about my child and his or her diagnosis? Who in the school should know? What special arrangements need to be made on behalf of my child? These questions are resolved on a case-by-case basis depending on the type of school, the quality of the school environment, and the relationships of the parents to the school personnel.

Further questions to clarify these concerns are: How understanding is the teacher toward children with special needs? What is the current relationship between the teacher and child, and between the teacher and the parent? Are there concerns about maintaining confidentiality regarding the child’s problems and diagnosis? Does the school principal demonstrate flexibility and commitment to children with special needs and willingness to make exceptions to the rules? What are the special services that would be available to the child, e.g., an aide or a learning resource room? What are the laws pertaining to the school’s responsibility for arranging special services for emotionally or behaviorally impaired students, and what are the federal or state agencies monitoring the enforcement of these laws? The therapist should have information readily available to help parents confront and resolve these issues.

Ultimately, parents make the decision about how much information the school should have about their child’s problems. Whether the school is notified about the specific diagnosis or not, the therapist should advocate regarding the child’s needs and collaborate with the school personnel to develop a plan. In most cases of dissociative children in the primary grades who were experiencing severe learning and behavioral problems, the parents and I have agreed to notify the teacher and school social worker about the child’s past history and resulting dissociative disorder. In these clinical cases, the school social worker, the teachers and other school personnel have been most helpful in modifying the child’s schedule and lowering expectations regarding completion of assignments and evaluations of the child’s performance. Meetings have occurred with therapist, teacher, school social worker, principal, and learning resource specialists to map out a plan. One highly dissociative 8-year-old DID child, who had uncontrollable switching of personalities, was assigned an aide to sit with her in the classroom. Because of her extreme distractibility, a screen was placed by her desk so she could keep her focus on the work and not distract the other children; this allowed her to be mainstreamed in a regular classroom.

In another school an 8-year-old DID girl, Susan, who had masculine and aggressive alters, would frequently exhibit disruptive and behavioral problems in the classroom and on the playground. A series of school meetings occurred in which a partial day program was temporarily arranged until her dissociative features were under control. A tutor came to her
home in the afternoons to supplement her learning. The school social worker would coordinate her therapy with the author and see Susan weekly in school and periodically at her home to observe her and provide support and guidance to her mother. Over a 4-month period Susan eventually returned to a full day at school.

With dissociative teens in middle and high school who have many teachers, it is advisable that only a select group of people know about the child’s diagnosis and scope of trauma, to help maintain confidentiality and prevent stereotyping. Generally the school social worker/counselor may have more information about the teenager’s problems, while the teachers may have only general information that the teen has problems affecting learning and behavior. It is advisable to provide just enough information to the school personnel to be helpful in modifying the school curriculum and expectations for the teen.

Success of a specialized academic program for a dissociative child is dependent on educating the school system about dissociation. Therapists can provide an in-service with the school personnel to alert them to indicators of childhood dissociative disorders and provide an overview of intervention strategies in managing these children in school. In cases where this has occurred the schools became more receptive, flexible, and committed to the dissociative children. When schools are educated about childhood dissociative disorders and treated as a respected partner with the therapist and parents, they become crucial partners in the child’s recovery.

Once the school has some understanding about the child’s problems, realistic expectations for the child and a program designed to meet those expectations can occur. Regular coordination and communication between parents, therapist, and school personnel is necessary. My experiences with schools have been a positive joint partnership as specialized programs were developed. (See Chapter 15.)

5. Advise parents to keep a journal of their child’s behavior.

Keeping a daily journal regarding the dissociative child’s emotional and behavior states is a most valuable tool in monitoring many aspects of the child. It helps the parent monitor the child’s struggles and progress and track the child’s dissociative features (times in which alters were present, child’s amnesia to behaviors, etc.). A daily journal can demonstrate a pattern the child may have regarding certain problematic behaviors the child or alters may exhibit over a period of a week or a month. One parent used a large monthly calendar to note her DID adoptive daughter’s personality system and associated behavioral problems. She realized that one of her daughter’s alters would have difficulty on Fridays and Saturdays, which were the former visitation days at the mall with her biological mother.
Once there was a connection made between those days and the disturbing memory, the adoptive mother and therapist worked with that alter to sort out her feelings of unresolved attachment to her biological parent. An environmental change was made in which Friday and Saturday visits to the mall were avoided and other structured activities were arranged on those days. These strategies helped the alter resolve the conflicts she experienced at those times. Maintaining a daily journal provides useful information about significant triggers and patterns of behaviors by the child and the alters which otherwise may be missed.

6. Parents are introduced to the child’s alters and they “adopt” each other.

It is common for parents to be familiar with the child’s alters while living with the child, but not understand that they are alter personalities. The parents are confused by the child’s sudden change in food, taste, or behavior. Parents express relief at finally being able to make sense out of their child’s many contradictory and perplexing behaviors when they become formally introduced to the alter personalities. One parent was enlightened when she was formally introduced in a family therapy session to a male alter of her 13-year-old DID daughter who liked to dance for hours, contrary to the quiet birth personality who spent time reading in her room. It is important for the parents to be formally introduced in family therapy session to their child’s alters and to learn the origin of the alters, their likes, dislikes, thoughts, and feelings. Parents and therapist should not assume that the alter personalities perceive the child’s parents as their parents. In my clinical cases, some of the alters did not perceive themselves as having parents, and some perceived themselves as having different parents from the child. The goal of the therapy is to help the alters and parents learn about each other, accept each other, and adopt each other. (See Chapters 8 & 9.)

Parent or Adult Alters. One common challenge for parents to contend with is conflicts over alter personalities who are adults or “parents” to the child. A 9-year-old adopted DID child had an adult alter who did not want to give up her control and authority. The therapist persuaded the adult alter that the parents were present now to protect the child and that she did not need to continue to assume that role but could begin to enjoy life. Finally the adult alter agreed to work with the parents in carrying out appropriate expectations for “their child.” However, until conflicts over control and authority are resolved between the maternal or adult alters and the parents, alters need to understand that the parents are in charge of the home and managing the child. As the mother or adult alters view the parents as advocates and protectors, then they are more likely to re-
linquish their parental or adult authority. Family therapy sessions with a child and his/her alters talking with the parents about their respective feelings and thoughts regarding traumatic events, and conveying mutual respect will pave the way for a "formal adoption." In the above example of the 9-year-old, after several family therapy sessions the adult alter consented to being adopted by the child’s parents and spontaneously regressed to the child’s age. The challenge over control among the parents and adult alter was resolved through mutual respect and understanding of their perspective roles, acceptance, and lastly, “adoption” of each other. The adoption between alters and parents can be a simple exchange of acceptance of each other in the therapy session or a more formalized ritual or party.

7. Refer parents for individual or couples therapy as required.

As discussed in the early part of this chapter, if the biological parents of dissociative children were the abusers of the child, they most certainly need to be assigned to their own therapist and receive the appropriate therapies. It is important to assess the parents for a possible dissociative disorder since there has been some research suggesting a multigenerational history of dissociation (Braun, 1985; Coon, 1985; Kluft, 1986; Waters, 1990). Benjamin and Benjamin (1994) describe a detailed family treatment model in working with children of dissociative families. If the biological parents were not the abusers, they may need to receive therapy to deal with guilt or blame they feel which could interfere in their ability to be firm with their child.

Adoptive parents of a dissociative child may also need to receive psychotherapy if the dissociative child’s behavior triggers unresolved issues of abuse in their past. One adoptive mother of a DDNOS (Dissociative Disorder Not Otherwise Specified) teenage girl began to have flashbacks of horrendous physical abuse rendered by her own biological mother when her adoptive daughter physically assaulted her. The daughter, who was afraid of attaching, was temporarily placed in foster care and received psychotherapy. The adoptive mother entered individual therapy to resolve her own issues pertaining to her early physical abuse. The adoptive mother’s successful recovery appeared to be the most effective intervention in the eventual return of her daughter, who had made only minimal gains in foster care and in her individual therapy sessions. The adoptive mother was able to maintain control and calmness when her daughter attempted to intimidate her during family therapy sessions and visits. The mother was loving, patient, rational, and consistent in saying to her daughter that she belonged at home with her family. The daughter realized that her manipulations to set up her parents to reject her were no longer working, and she agreed to return home. On followup she ap-
peared to have successfully attached to her adoptive family, and she and her mother joked about the daughter’s past “shenanigans.”

Therapists need to evaluate for abuse in parents’ history regardless of whether the parents are biological or adoptive parents. The therapist needs to determine if the parent’s past history of trauma is affecting her ability to deal with her child’s history of abuse. Providing parents with needed psychotherapy so they can deal with their own issues of trauma can be crucial to the parents’ ability to effectively deal with their traumatized child. Treating the traumatized parent may be the determining factor in holding the family together while the dissociative child is recovering.

8. Assist parents in receiving respite care.

Parents of a dissociative child may feel as though they are psychologically dealing not only with one child but with a group of children. Great demands are placed on the parents emotionally, physically, and financially, and the burnout rate is high. To avoid total parental burnout, which would threaten the home placement and/or place the child at risk for maltreatment, the therapist should explore with parents respite care options at the time of diagnosis. Some options may be relatives, college students majoring in social work, psychology, or related fields, and community mental health centers with respite care programs. I have met with college students who agreed to provide respite care. I have educated respite care providers about the child and have given specific guidelines on structuring activities and dealing with potential problems with the child. Respite care providers are a necessary link in the chain of helping families with dissociative children.

9. Provide a parental support group

A parental support group of parents with dissociative children can be an invaluable support system. Monthly meetings with the parents and the children’s therapists sharing struggles and solutions can enlighten and strengthen the parents’ resolve to “hang in there,” particularly when they are feeling hopeless or extremely frustrated. Rules of confidentiality are set. Parents can share phone numbers, if they agree. My parental support group became a creative vehicle for developing problem solving techniques. They were able to laugh and cry together. Their experiential sharing of what it was like living with a dissociative child could not have been provided in any other way. Brand (Chapter 11) describes a helpful parenting group for parents of teen dissociative patients, for which the teen must give formal permission.
Child Management Guidelines

It is difficult to anticipate the unusual family problems that may arise, with the constant interaction of patients and their alters with parents, siblings, friends and extended family. Clinicians and parents must be flexible in responding to the individual challenges of each unique dissociative child. However, the guidelines below are viewed as universally applicable to all dissociative children and may provide a framework for resolving management questions.

1. **Use only non-physical forms of discipline.**

   A dissociative child who has been traumatized sexually or physically is very susceptible to tactile triggers related to early memories of abuse, even if the touch is an appropriate one. Incidents such as a sudden tap on the child’s back may initiate a profound startle reaction, and parents may become accustomed to avoiding unexpected touches. It is important to stress to parents that purposeful hitting, pushing, spanking, or slapping are never acceptable forms of discipline for a dissociative child. These assaults to the child’s body can set off a full blown abreaction to early physical forms of abuse and strengthen the child’s dissociative defenses. These children have learned aggression from their maltreatment, and physical forms of discipline may increase these aggressive and retaliatory tendencies.

   Because these children are very provocative, they require parents who are well versed in appropriate child management techniques and can work out an agreed plan with the child in advance for appropriate rewards and consequences for chores and problematic behaviors. As with normal children, it is important to give consequences soon after the inappropriate behavior if possible and to employ grounding for a reasonable period of time. However, until there is co-consciousness in which the child and the alters share information and are all attentive, the parent should not expect the child to learn immediately from the behavioral interventions such as grounding and removal of privileges.

2. **Use a calm, low voice when the child is out of control.**

   Traumatized children may have been emotionally and verbally abused by screaming, shouting, and name calling. These emotional scars are hidden scars, which can be more damaging to the child’s self worth and identity than physical scars. The verbal abuse has an insidious impact on the child’s sense of being as the child feels splintered, insecure, demeaned, and enraged, and may want to retaliate. Given how demanding, provoca-
tive, and unrewarding a dissociative child can be periodically, it is a most challenging task for the tired, frustrated, and angry parent to maintain a calm, low voice when the child is screaming or refusing to listen.

When a child is out of control, it may be best not to try to reason with the child, but to separate the child from the parent. The parent may send the child to his or her room with the instructions that when the child has calmed down, then he or she can come out of the room to discuss what had occurred. Sometimes it may be advisable for the parents to remove themselves from the provocative child who is attempting to incite the parent's anger. This approach would be appropriate if the parent was not worried about the child harming himself/herself or others or destroying property. The parents can go to their bedroom or to the bathroom for privacy until the provocative cycle is broken.

One parent of a DID child reported that his petite 8-year-old adoptive daughter’s alter would scream in his face inches away when he was attempting to deal with her oppositional alter personality. If he yelled back, she would escalate, and the situation would quickly worsen. If he kept his voice low and calm, she was able to calm down sooner. Then, they were able to work out the conflict without a full-blown crisis.

It is very difficult for parents to separate out angry responses which their child has toward them and see their behavior as symptomatic of the abuse rather than a personal affront to them as parents. One adoptive mother, who was in a helping profession, reported to me that she could deal more effectively with her dissociative teenage daughter's angry outbursts by viewing her as a client rather than as her adoptive daughter who was resistant and fearful of attaching. Maintaining a psychological distance kept the mother from becoming entangled and embroiled with her angry, demanding, and unattached daughter. This "clinical" distance also provided some protection for the mother, who was psychologically hurt by her daughter's rejection.

3. When discussing with the dissociative child consequences, ask the child to have "all your parts (alters, fragments, ego states) watch and listen" so everyone is aware of the undesirable behavior and consequences.

The parent’s goal is to encourage the child to develop co-consciousness by requesting that the child's alters, ego states, or fragments watch and listen when the parent is instructing the dissociative child.

Parents should not assume that the child and the alters, fragmented personalities, or ego states are aware of the discussion following an inappropriate behavior, even when the child has expressed co-consciousness, because the alters may be "sleeping" or preoccupied with some other activity internally. Several dissociative children whom the author has...
treated stated that a helpful alter (one who has a positive influence) was "sleeping," even when it was agreed that all alters were to be attentive.

Another common dilemma with parents is managing the dissociative child's aggressive behaviors, e.g., hitting, swearing, breaking objects, when the child reports that the alter who committed the offense quickly disappeared leaving the host personality "holding the bag." These alters may "go into hiding" to escape from listening to the reprimand. To avoid or minimize this from occurring, the parent needs to make reference to the child and alters, if known, or "to any and all parts" that were involved in the misbehavior to be aware of the consequences decided. For example, the father can say to his dissociative daughter, "I want you and your parts to watch and listen while we talk about what just happened, and decide how it should be handled. Everyone needs to listen so they know the consequences."

Due to dissociative features, these children need frequent reminders about the rewards and consequences of unacceptable behaviors. Parents should not assume that the child will remember and learn from one incident to another what is acceptable and unacceptable behaviors. Until the child is further along in treatment in which amnestic barriers have eroded, and there is co-consciousness and cooperation, he or she will require continuous discussion of expectations, rules, and consequences.

4. No matter who was out or internally influenced the child at the time of the inappropriate behavior (alter, fragmented personality, ego state), the child still has to be held responsible for his or her behavior.

It is my general position that the dissociative child needs to be accountable for his or her behavior. Understandably, this will present conflicts of responsibility and ownership of behavior in the initial phase of therapy in which the identification of the dissociative system is unknown and amnestic barriers are still present. Therapist and parents can use judgment and flexibility in determining the degree of the child's accountability for inappropriate behavior by weighing many factors.

One critical factor to weigh in determining consequences is this question: "Is this behavior linked to a traumatic incident which the child is remembering and therefore acting out?" For example a child's inappropriate sexual behavior with a peer or a much younger child may be rooted in his or her own unresolved trauma. It is important that the therapist explores with the child the underlying dynamics and the motives of the behavior. The therapist assists the child to deal with the traumatic memory of sexual abuse and stresses to the child the serious legal and social consequences of sexually inappropriate behavior. The therapist, then, helps the parent understand the motives of the child's behavior.

Nevertheless, the parent would need to set up necessary environmen-
tal precautions to prevent or greatly reduce the opportunity for the child to sexually engage with or abuse another child, such as playing only in supervised areas, prohibiting sleepovers, or allowing only structured activities with peers outside of the home. These restrictions give the child the message that the sexually inappropriate behavior is unacceptable, and the child will have to learn ways to control future sexual impulses in order to be allowed more freedom with peers.

5. When the child denies a witnessed, problematic behavior, the parent gives the firm message that the child needs to sort out with the alters what occurred as the parent provides an understanding atmosphere.

Even though dissociative children are encouraged by parents and therapist to engage in co-consciousness and cooperation, the child may not always have an awareness of a destructive behavior exhibited by an alter. Restrictions should be accompanied by the strong message that the patient needs to do an internal check to find out what role an alter may have played in the behavior. This encourages inner communication, the eroding of amnestic barriers, and cooperation. The child’s task is to learn to work together with the alters to control any impulses.

When a parent is faced with a child’s denial of a witnessed behavior, the parent should calmly instruct the child to go to his or her room and explore internally what may have occurred, and later they will discuss the behavior and consequences. One astute adoptive mother of an 8-year-old DID girl told her when conflicts occurred between her and her alters, "It’s not up to me to fix it. You have go inside and fix it!" The adoptive mother understood her limits and encouraged her daughter to fix her conflict with her alters, and to arrive at an agreed solution. This approach worked well to minimize jealousy, competition, and resentment among the child’s alters, and to encourage communication, cooperation, and conflict resolution with them.

Another factor in evaluating the child’s denial and accountability for his or her actions is to consider if the child is manipulating to avoid responsibility for behavior by blaming an alter for the actions. The author knew one 10-year-old DID girl who would frequently try to fool the author and the child’s parents by pretending to be her male alter in order to blame him for her misbehavior. When she learned that it did not matter if it was her or her male alter, but that there were clear consequences for the misbehavior, her attempts to deceive her parents and the author decreased. In addition, her male alter was instructed to come out and take control, if needed, to prevent the child from getting into trouble and being grounded. The child and her alters had to work out together a way to deal with projection of blame, internal conflicts, and accountability for the misbehavior.
6. The therapist, child, and parent confer and identify internal helpers who are requested to assume control if the child or an alter attempts to engage in destructive or abusive behavior.

The author has instructed alters to be "watchers" and to take over, if needed, to prevent the child from engaging in destructive or aggressive behavior. Parents need to be aware who the "watchers" are and encourage them to take executive control or warn the parent if the child is going to engage in destructive or abusive behavior.

7. The therapist, parent, and child confer and agree on modified treatment techniques to be employed at home for safe discharge of feelings. The child is rewarded with an agreed-upon privilege.

Traumatized children need safe and varied methods to express and discharge their feelings. Frequently they have rage, which may be expressed in violence toward their family members, peers, or property. Providing acceptable discharge of such rage can minimize these destructive episodes. Arranging in advance privileges for safe discharge of intense feelings will encourage the child to employ these techniques.

The following are some suggested bargains that the parent can negotiate with a dissociative child to help with expressing anger:

1. punching a pillow or punching bag to earn points toward a toy;
2. drawing a picture of their feelings and ripping it up to earn points toward renting a video;
3. making a snow sculpture symbolic of feelings and then smashing it to earn the privilege of a favorite bedtime snack;
4. making a sand sculpture symbolic of feelings and stepping on it to earn the privilege of inviting a friend over;
5. making a clay figure symbolic of feelings, and smashing it to earn points toward the privilege of ice skating, roller blading, or roller skating;
6. running down the driveway or around the block three times a week to discharge anger to earn the privilege of attending a favorite sports event;
7. using an exercise machine to expel anger in exchange for time playing a computer game;
8. shooting baskets to expel anger in exchange for watching a favorite television show that day;
9. journal or write poetry about feelings three times a week in exchange for going to a movie.
10. Most importantly, verbalizing to the parent the anger felt and requesting parent’s help in processing thoughts and feelings in exchange for spending special time with the parent.
Each family needs to evaluate what opportunities are available and acceptable in their home environment to express rage. One family, who resided in a rural area, agreed on a creative solution for their adopted 10-year-old DID girl. She was permitted to go to the woodshed, which also contained garbage cans, and shake them, scream, and swear. She understood that this was the only place in which she was allowed to use vulgarities toward the abusers who had sworn at her profusely.

Another devoted adoptive mother who also resided in a rural area would make use of her quarter-mile driveway when her 8-year-old DID daughter would become rageful at bedtime. The mother would bundle up her daughter and march her up and down the driveway until her daughter was able to calm down and verbalize her anger, hurt, and fears. Then the mother would rock her daughter and put her to bed.

The therapist and parents need to review techniques which they find acceptable and agreeable and permit their child to voice what she is willing to do to safely discharge negative feelings. Children can suggest creative techniques that adults might have overlooked. Children need to decide with parents what rewards would be meaningful to them when they use appropriate expression of unpleasant feelings instead of destructive behaviors.

8. Therapist, parent, and child agree on code words or symbols to signify the presence of intense, and uncontrollable feelings, thoughts, and behaviors.

It is advisable for the therapist, parent, and dissociative child to select code words or symbols which can be verbalized by the child, parent, therapist, teacher, and other appropriate adults to signify that the child is in need of quick stabilization. Code words or symbols can be used for the following purposes:

a. The child may be experiencing intense and uncontrollable feelings, thoughts, and behaviors which could result in destructive behaviors.
b. The child may be experiencing a flashback of a traumatic memory and needs to be reoriented to the present.
c. The child may be dealing with conflicts with alters over executive control of the body or over a desire to hurt someone or oneself.
d. The child may be disoriented and switching personalities and needs to maintain co-consciousness and cooperation.

The expression of code words or symbols can be a quick way to halt the escalation of serious behaviors without exposing the child to humiliation in front of peers or other adults. This is an intervention tool to redirect the child to being appropriately oriented and under control.
The code words "get it together" have been used by parents, teachers, and therapists with DID and DDNOS children who appeared disoriented and had uncontrollable switching of alters or ego states influencing the child to act developmentally inappropriate, exhibit extreme mood switches, or experience difficulty in performing needed tasks, e.g., homework or chores. This word signified to the child and his or her parts the need to come together in co-consciousness and cooperation.

The symbolic word "spike" was used by a DID child to report to her parents when she was experiencing intense feelings or new memories. Sometimes her parents would use the word when they suspected that their daughter was having a new memory, saying, "Are you having a spike?" One child used the symbolic word "bubbles" to signify when he felt that he was "going to burst" with overwhelming emotions and might hurt himself or someone else.

For one child the symbol of the child's hero figure, Power Ranger, was employed to reorient the child to the present when the child was experiencing a flashback. The hero figure was seen as the child's protector who gave the child the emotional support to come back to the present environment because his hero was watching over him.

In order for code words or symbols to be effective, the child and alters should select the code words or symbols and agree to comply with the use of them. Sometimes children may become resistant or oppositional to using them. A frank discussion with the child about effective ways to help him to have control over himself to spare him any embarrassment or a long discussion may be required to regain the child's commitment to responding to the code words or symbols. Hypnotherapy (Kluft, 1985b) may be employed to instill code words to help stabilize the child, if the child is agreeable to this technique.

Summary

Therapeutic approaches involve assessment of the family's functioning, counteracting any abusive elements in the dissociative child's environment, and contracting with the parents to provide a safe and supportive setting for effective treatment. Making appropriate referrals and close collaboration with protective service agency are essential when there is a threat of abuse. A multidisciplinary team approach with schools, criminal justice system and others can provide the different interventions needed to treat chaotic families, while the therapist works with the parents on specific techniques to maintain the child at home. Treating the child in a safe and nurturing environment with caring and stable parents is necessary for the child to begin to remove dissociative barriers, uncover the personality system, reveal traumatic material, and reach a state of personality integration.
Parents of dissociative children face many obstacles in managing their children. By learning to accept and interact with the dissociative aspects of the child, learning how to manage difficult traumatic memories, and helping the child manage his extreme emotions, the parent serves as a therapeutic collaborator in the child's treatment. With adequate knowledge, support, and commitment, parents can play an integral role in facilitating their child's recovery. Therapeutic work with parents is an essential component in the full treatment plan. Parental perseverance will facilitate the dissociative child’s attainment of trust and attachment and promote the child’s development into a functioning adult.

References


When individuals come into therapy, they come with a retinue of family. Some family is internal (early family dynamics) and some family is external (present day events). With adults, the therapist works indirectly with both these families. With children, the therapist similarly works indirectly with the internal family, but the work with the external family must be direct. This work inevitably brings a new set of challenges for the therapist.

As trauma therapists, we are well aware of the need to address the multiple and unstable representations of the internal mother (persecutor/victim/care-taker) (Liotti, 1999) but, all too often, we mistakenly assume that the present parent – be it birth, step, adoptive, or foster – bringing the child to our office is a stable figure. This parent has recognized the child’s distress, the child’s need for therapy; this parent wants the child’s world to be more stable. This recognition and wish may indicate the parent is stable or it may come from the parent’s own sense of instability.

Therapy for a child with dissociation is unlikely to be successful on a long-term basis (that is, maintained beyond the time of therapy) if the child returns from therapy into a setting where the parent is responding from his or her own unresolved trauma. If the parent responds to the child with multiple presentations (frightening other, frightened other, care-taking other), the child, of necessity, needs to maintain multiple internal self-models (victim, persecutor, cared for) (Liotti, 1999). As child therapists, we must address a parent’s need for therapy.

Two major blocks occur: funding and willingness by the parent. Coverage for therapy can usually be procured for the child who has been victimized; funding for the parent is far less accessible. Therapy may require (1) splitting the child’s fee with a colleague who is willing to see the parent at half fee or (2) providing therapeutic processing for the parent within the child’s time. The first alternative is the ideal, but it assumes not only generous colleagues but also a parent who is willing to look at his or her own experiences and internalizations. With the second alternative, the child unfortunately loses some of his or her time as well as the therapist being dependent on the parent’s openness to working on personal issues.

For the parent who is unwilling to engage in therapy (and these are the parents least able to see the child separate from themselves and their own childhood issues), the child therapist is left with the challenge of creating a new relationship experience for an individual still caught in the past.

All too often, we mistakenly assume that the present parent... bringing the child to our office is a stable figure.

As the parent talks about the child and his or her experiences with the child, the therapist can listen and validate. This listening and validating casts the therapist into the role of ‘supportive other’ to the parent. To give the parent an experience of a consistent single positive model of other, as opposed to the early disorganized (multiple-model) attachment we can assume this parent had, we have to be very careful. If we start to point out parenting errors, we may become the ‘critical/persecutor other’. Educating about trauma and dissociation, an important part of the first stage of therapy for a child with dissociation, can help the therapist stay in a supportive role. Educating provides corrective ideas as to what the child needs while allowing the therapist to maintain a distance from the parent’s actual behaviors. But many parents, because of their past experiences, are either not able to understand the ideas presented or not able to make personal use of the ideas.

Questions such as: “When did you, as a child, feel like this?” “Perhaps you as an adult have felt that way – what was it like?” “What do you think it would be like to feel that way?” “What do you wish your parent/your partner had done then?” “Yes, you should have had that,” can enable the therapist to stay as a supportive figure while encouraging some internal identification with the child. “What do you think your child was reacting to when s/he did that?“ “Where do you think your child’s feeling, sensation, thinking came from?” “What might help your child with that experience?” The questions suggested above are best asked when the therapist is meeting alone with the parent and when there is time for the therapist to follow whatever content the parent raises. The therapist will want to avoid questions such as “How did you get through such experiences?” “How do you want your child to be different?” because the ideas generated by these questions may re-enforce negative or dissociative behaviors.

When working with the child and parent together, the therapist can have both the child and the parent identify the emotional feelings and body sensations that come with particular situations or topics. This method provides both the child and the parent with increased self-awareness and enables those parents who can to attend more closely to their children. These sensations can be attended to, slowly shifted (see Levine & Kline, 2007), and then redescribed by both the child and the parent. This technique provides some processing for old fears or anxieties at the same time as giving the parent a tool to use with the child (and with themselves) at home.

Meeting with parents separately to clarify their behavioral expectations of the child and their system of correcting and teaching

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the child is important. Parents who have been experiencing chaos within the home are usually appreciative of the structure these sessions can provide. Therapists can often learn a great deal about the way the parent was raised from these sessions. How parents want their child's life to be the same or different from their own can be highlighted. Ideas to make this happen can be worked on together. Consistency and follow-through is always emphasized both by the therapist's explanation and by the therapist's own behavior (i.e., the therapist must be consistent and follow-through with the parent just as she wants the parent to be with the child).

Helping parents identify the triggers that cause shifts within the child and providing them with phrases for grounding the child reinforces the therapist as the 'supportive other.' Therapists can help parents modify or eliminate triggers at the beginning of therapy. Later the therapist and parent can work as a team to slowly reintroduce the triggers. The parent, as part of the team, learns to talk about the present safety and the difference between the past and now. As parents talk to the child about these positive changes, parents are also talking to themselves and building a new sense of safety for themselves. As parents become more aware of what triggers their child, they may also become more aware of what triggers them. The therapist can play an observer role in this process (“I wonder if that might be a trigger for you too?” “I noticed you becoming quiet then. Perhaps my comment triggered something for you?”)

Therapists can teach parents integrative-type language to use with their child. “I am aware that seeing your brothers can make you really angry but I need the thinking part of you to be there as well the angry part so no one gets hurt on the visit. Then after the visit, the angry you can tell me all the feelings and thoughts, and sensations that came up.” “The you that has been safe here for the last six months can let the scared you know that this house is safe.” “This hug is for all of you—the you that breaks things and the you that takes care of things.” Because these comments help a child settle down, parents have a sense of progress and of being able to help their child. Our noticing and commenting on any small positive changes by the parent (even if only momentary) is important.

Advocating for parents with protective services, the school system, and the health system also reinforces a supportive role for the therapist.

Additional issues come up when the child is in a foster home or residential setting and is having visits (supervised or unsupervised) with the original parent. It is important for the therapist to meet with this parent. Recognizing the hurt, and perhaps shame, this parent is experiencing from having his or her child removed is an important place to start. The therapist here plays a dual role: the therapist wants to support and help the parent and, at the same time, is assessing whether continued contact and what type of contact is beneficial for the child. From a child’s comments, the therapist can usually tell what sorts of messages the parent is giving to the child. Of course a parent wants to tell a child that s/he wants the child home and is working to make this happen. And the child wants to hear it. But this message stops the child from building an attachment to the new ‘parent figure.’ Helping a parent recognize what may or may not be possible and how to talk to the child about these possibilities will be important for the child’s stability and for a stable base on which integration can occur. When this discussion is not a possibility, then the therapist must work with the child to help the child recognize the parent’s limitations.

When the therapist, in her work with the parent, does shift into a corrective role (and inevitably this does happen either with words or attitude), it is important for the therapist to name what she has done and ask about the parent’s experience of the shift. The parent may minimize what has happened but it is the therapist’s job to correct herself and take responsibility (it is our job to support, to educate, to explore, to develop ideas, but not to correct). It is then our job to re-establish the supportive relationship. Maintenance of a consistent supportive relationship with the parent is essential if the parent is to have an experience (albeit a small experience within the parent’s whole world) of a steady, secure attachment. It is this steady, secure attachment that can provide a base for a single positive self or an integrated multiple self. With the single or integrated self, the parent can provide greater stability for the child.

All of this discussion may occur while the parent is in the room with the therapist and child at the beginning or end of the session or when the parent is seeing the therapist alone at the beginning of the session or in a separate session. Yes, this is time taken from the child’s therapy. But it is time that enables the child’s therapy to be successful.

Maintaining a supportive stance can be extremely difficult when the parent’s behavior toward the child and, indeed, the parent’s attitude toward the child is destructive. We are, after all, first and foremost the child’s therapist. Consultation where the therapist can express her frustration and even anger with the parent is essential. This processing enables the therapist to come back to the importance of her relationship experience with the parent. It helps the therapist remember that the parent does not choose what Siegel and Hartzell (2003) refer to as the ‘low road’ of parenting; it occurs from past experiences the parent has not been able to process. For the child to benefit from long-term therapy, the parent needs a new relationship experience. Consultation - with colleagues and within one’s own mind - can help us come back to the next therapy session without critical judgment.

However hard we as therapists work, we cannot always prevent destructive situations: a parent’s distress keeps the child in a state of anxiety; the child’s anxiety behaviors trigger the parent’s fears and multiple negative responding by the parent occurs. We need to be alert to these interactions and to when they reach a level at which neither the parent nor the child is going to be able to de-escalate. It is at this point, whether the home is a foster home, an adoptive home, or a birth or step-family home, that a move needs to be considered for the child. Safety and stability for the child is our primary objective. No therapy can occur without it.

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