Dissociation often emerges as a physiologically-based coping mechanism when a primary caregiver is grossly inconsistent and unavailable to an infant or young child and when other traumas occur during development (Putnam, 1997). Such repeated or chronic traumas make it necessary for children to protect themselves when faced with abandonment/neglect, chaos, inconsistency, and direct sexual, physical, and emotional abuse. Dissociation is a psychophysiological process that can protect children facing overwhelming emotions, body sensations, and/or knowledge of those experiences by enabling them to split-off and separate these reactions from conscious awareness (see Schore chapter, this volume). This however can lead to a sense of not having a stable and reliable sense of self, of the world, or of others that, over time, can lead to fragmentation of the child’s identity.

The current chapter offers discussion of the various levels of dissociation that may occur in children who have experienced developmental and other forms of trauma and their dissociative symptoms. We trace the development of awareness of dissociation within the mental health community and describe the process of dissociation from neurological and other conceptual frameworks. We explain why, when treating traumatized children, it is important to apply a
therapeutic approach that identifies dissociation and gradually ameliorates entrenched dissociative patterns. A case study of a child with a dissociative disorder is used to illustrate these concepts.

**Levels and Symptoms of Dissociation**

Normative dissociation, such as getting absorbed in a video game or driving to work without being aware of the route taken, is a common phenomenon in both children and adults. Dissociation is quite different and less normative however when it is used to escape awareness of and feelings and sensations associated with traumatic experiences, events, exposures, and environments. Originally, it may occur spontaneously in children as a psycho-physiological response to repeated circumstances of fear, threat, and insecurity. Over time and in the face of ongoing danger, its use may become automatic, non-voluntary, and progressive. While its use is initially protective, it may become problematic and pathological when over-generalized and applied outside of its original context, when it becomes automatic in response to cues associated with the unresolved trauma, and when it extends into adulthood. Although the sensations, feelings, knowledge, and learned behaviors resulting from overwhelming events may be blocked from conscious awareness, they are encoded neurologically and somatosensorily (Schore, 2003; Van der Kolk, 2005). When an infant/child is traumatized and does not receive needed attention and consistent caring, soothing, and response, he or she must find other ways to cope and to self-soothe. Over time and while under ongoing states of duress without protection from harm, the traumatized child develops separated-off segments of memory, knowledge, emotion, or patterns of relating that are internalized (Nijenhuis, & Steele, 2006). The self may no longer be “whole,” and the dissociated memories and sensations may be perceived as not being under the control of the conscious and executive self (for more detailed description of dissociative states see Wieland, 2011; Silberg, in press; Silberg & Dallam, 2009 and Van der Hart et al., 2006).
Mild Dissociation

When a child is experiencing a mild level of dissociation (a blocking of awareness of what is going on around him/her), other people may notice that the child “spaces out.” This child may show extreme reactivity (high upset or total withdrawal) without any of the “in-between” associated with normal emotional shifts. The child in such a state is often unable to identify his or her own environment, emotions, or body sensations. At other times, the child may experience strong emotions as taking over and may perceive that he or she has little ability to control behavior, particularly when angry. The child may have some elaborated imaginary friends who are used as protection and soothing in times of stress but the child knows these are imaginary. The child may struggle with remembering recent or past events or school-related information, but can generally access needed information with prompting. The child is aware when frightening events are happening or have happened, and is generally aware of what he is doing and feeling.

Moderate Dissociation

From the outside, moderate dissociation in a child may look quite similar to mild dissociation – diffuse “spaciness” and inattention and difficulty naming feelings and sensations on one hand and overreaction on the other--to what appear to be innocuous situations. The child’s reactions are incongruous in ways that do not fit the situation. The child may swing quickly between feeling states, for example, between excitement and hopefulness at one extreme and extreme discouragement or hopelessness at the other. The child feels disconnected from the outside world, for example feeling outside of an event watching it happen (depersonalization) or inside the event but perceiving it to be unreal (derealization). Depersonalization and derealization usually initially occur in response to a frightening or terrifying experience or event but then continue to
occur in situations similar in some way to the original circumstance. The child with moderate dissociation may also report imaginary friends who are perceived as having a life of their own.

**Extreme Dissociation**

A child with extreme dissociation may have experiences of self as divided between different states or identifies that hold separate information, emotions, physical sensations, or experiences. There may be baby-like states that provide a sense of respite for the older child through regression. There may be frightened self-states in which the child remembers a trauma and is easily triggered into fear and terror responses, or angry self-states who lash out and often serve a defensive or protective function. The child may feel divided among several parts of self that experienced trauma at different ages, some at his or her present age and even, for some children, an older part that developed to cope with difficult situations and to parent and soothe the child “from the inside.” These children often have significant memory gaps and difficulties (amnesia) for recent and past behaviors. If the child reports imaginary friends, he may perceive them as real and as sharing or taking over control of feelings and behavior.

From the outside, the child’s eye gaze, facial expression, voice tone, body position, way of interacting or developmental level may shift so dramatically that the parent or teacher perceives a completely “different child.” The child may become unresponsive to current surroundings for a period of time, ranging from several seconds to minutes to hours. At other times, the shifts are more subtle and the parent or teacher is simply left with a sense that the child is not functioning normally or is highly labile or excessively moody. It may take little by way of triggering to set off responses of shutdown or over-reactivity in this child who may also demonstrate radically different interests, food preferences, skills, or levels of attachment at different times and in different states of self. There may be physical problems related to different areas of the body—pain, movement, lack of
control – for which there are no medical causes or reasons and which may come and go (i.e., in the form of somatoform dissociation; Nijenhuis, 2009). Subjectively, the child may experience sudden shifts in internal experiencing, including hallucinatory symptoms such as hearing or being aware of different voices in their head. Some children may talk aloud to themselves using different voices and use different names for themselves. At different times that they may insist others use these different names. Additionally, the child may be amnestic, in a global or in more circumscribed ways, including for awareness of positive as well as distressing relationships and experiences.

Per criteria included in the *DSM-IV*, when the child (or later the adult) retains awareness of other states or ways of feeling or being, he or she is likely to meet criteria for the diagnosis of dissociative disorder not otherwise specified (DDNOS) (American Psychiatric Association, 2000). When the child or adult in one identity state is amnestic for experiences in other states and one or more states emerge to take executive control of the self, the child then meets criteria for the diagnosis of Dissociative Identity Disorder (DID) (American Psychiatric Association, 2000). The child may or may not give specific names or other defining attributes (age, gender, feelings) to these dissociated identity states in either diagnosis.

Children with trauma-based dissociative symptoms often present similarly to children with other childhood disorders, in ways that can make differential diagnosis difficult. For example, the dazed looks and problems with attention and focus may be confused with the symptoms of Attention Deficit Disorder (ADD) or the child’s dramatically shifting states and moods may resemble bipolar disorder. An out of context angry response to mild requests may look like bipolar, oppositional defiant disorder, or conduct disorder. In fact, dissociative disorders may co-occur with each of these other disorders. It is essential in situations of co-morbidity that dissociation be recognized since the dissociation requires its own treatment—one that is specific and direct.
Recognition of Child Dissociation and the Need for Specific Therapeutic Interventions

Although the case of an 11-year-old child with extreme dissociation was described by Despine in 1840 (see McKeown & Fine, 2008), it was not until the 1980’s that clinicians and researchers began to address this phenomenon of dissociation in children. Kluft (1984) hypothesized that dissociation in adults was a function of childhood trauma and would, therefore, have originated in childhood. Kluft also identified dissociation in some of the children of his adult patients and went on to successfully treat them using hypnosis, as he did with his adult patients (Kluft, 1984). In the late1980’s and 1990’s, additional cases were reported in the literature (see review by Silberg & Dallam, 2009). Diagnostic measures including the Child Dissociative Checklist (Peterson & Putnam, 1994), Children’s Dissociative Experience Scale (Stolbach, 1997), Adolescent Dissociative Experiences Scale (Armstrong, Putnam, Carlson, Libero, & Smith, 1997), and the Adolescent Multidimensional Inventory for Dissociation (Ruths, Silberg, Dell, & Jenkins, 2002) were developed for clinical practice and research. In 2004, dissociation was included in the guidelines for the treatment of child abuse released by the National Crime Victims Research and Treatment Center (Saunders, Berliner, & Hansen, 2004). More detailed guidelines for assessment and treatment of dissociative symptoms in children were released by the International Society for the Study of Dissociation in 2004 (www.ISSTD.org). Developmental Trauma Disorder (van der Kolk, 2005), proposed for inclusion in the American Psychiatric Association’s fifth revision of the Diagnostic Statistical Manual includes dissociative symptoms as one of the common outcomes for children exposed to chronic attachment and other forms of interpersonal trauma.

Research demonstrates that dissociative symptoms are common in a broad range of adolescents in both clinical and non-clinical populations, including in delinquent youth (Carrion & Steiner, 2000), psychiatric inpatients (Brunner, Parzer, Schuld, & Resch, 2000), and girls with
eating disorders (Farrington, Waller, Neiderman, Sutton, Chopping, & Lask, 2002). Dissociative symptoms have been found to be strongly associated with sexual abuse (Trickett, Noll, & Putnam, 2011) and to be related to sequelae of chronic medical trauma and treatment, particularly when a painful procedure is employed and parents are involved in its implementation (Diseth, 2006). Child dissociation also has been found to be related to histories of disorganized attachment with primary caregivers, especially when early attachment problems lead to ongoing fear and terror in the family associated with chronic abuse and lack of caregiver response and protection (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997; see also Schore and Alexander chapters, this volume).

Understanding the way a traumatized child who dissociates may process information is a necessary first step toward developing a therapeutic approach. Deficits in right brain cortical integration of sensory information are related to the development of dissociation and may leave the traumatized infant/child without an integrated sense of self (see Schore and Lanius et al. chapters, this volume) and altered awareness of pain and visceral sensations (Bremner, 2009; Lanius, Bluhm, & Lanius, 2007; de Kloet & Rinne, 2007). Such neurobiological alterations are consistent with findings from research on early childhood interpersonal trauma and disorganized attachment (Schore and Alexander chapters, this volume). Liotti (2009) describes the shifting behaviors of the mother figure (comforting, needing comfort, hurtful/frightening, hurt/frightened) which places the child into the opposing positions of being comforted, having to comfort, being hurt/frightened, creating hurt/fright. These shifting relational stances characteristic of disorganized attachment can lead to the fragmented information processing and self-fragmentation seen in dissociative children. Similarly, Putnam (1997) described how traumatized children may not develop integrated behavioral states that occur as a consequence of healthy development. Instead, they show discrete (rather than continuous) behavioral states—sometimes from the time of infancy-
-that connote fragmented experience and information processing. These observations are consistent with the structural model of dissociation (Van der Hart, et al, 2006): when trauma is repetitive and severe, fundamental divisions of the self may occur that make it increasingly difficult for the child to maintain personal integration or integrated awareness of self or others.

Similarly, but with a focus on the integrative role of emotion in information processing and adjustment, Silberg (in press) proposes that overwhelming affect during early life trauma disrupts the development of the psychobiological affect regulation system. In order to eliminate what is overwhelming, the traumatized child seeks to avoid arousal and affect. With continued trauma, this avoidance response that becomes triggered by the many stimuli that serve as trauma reminders. Dissociative responses are understood as the initiation of automatic avoidance processes of behavior, identity, and affect that take over functioning without the child’s central awareness in response to reminders of trauma (Silberg, in press).

**Dissociation-Focused Therapy as Integral in Treatment of Complex Traumatic Stress**

A sequenced model of treatment usually organized in three stages has been suggested for complex trauma resolution in both children and adults, involving phases of: (1) safety, stabilization, and strengthening, (2) trauma processing, and (3) reconnecting with the world (Herman, 1992). Such sequencing has recently received support from a survey of a cohort of identified experts in the treatment of complex and more standard forms of PTSD in adults, (Cloitre, et al., 2011), a finding that is applicable to the treatment of children and adolescents. The importance of the identification and treatment of dissociation in each stage is increasingly recognized. Without attention to dissociation, treatment may be beneficial but will not be complete, all too often leaving the child (and later the adult) with unresolved split-off emotions sensations, behaviors, thoughts or states of awareness (Silberg, in press). When children or teens
are not treated for dissociation, they are more vulnerable to further dissociation, particularly, when faced with traumatic reminders or other difficult events and experiences in the future. Traumatized and dissociative children may not be able to fully experience the therapist, the therapeutic interaction, or themselves as a participant in therapy due to their ongoing fragmentation. This too makes it imperative that dissociative process be identified and treated.

**Stage One Treatment**

Stage one of trauma treatment starts with assuring that the child is living in conditions of safety and has relatively secure attachment relationships and helping the child develop an internalized sense of safety as well. Over time, the information about present safety needs to be passed to all parts of the self when the child is highly dissociated (see Silberg, in press; Wieland, 2011). The therapist at this stage might engage the child in drawing, play, or conversation that begins to elicit and assess the child’s use of dissociation and the extent of the dissociative process. For example, the child can be asked to draw a self-portrait where conflicting parts of the mind are illustrated, or the child can be assessed in play and conversation for evidence of dissociation.

Education about dissociation for both the child and the parent needs to occur early in the first stage of treatment (Silberg, 1998). For children, dolls or toys with multiple parts, and for adolescents, diagrams as well as drawings may be used as a therapist explains how children can use dissociation as a means of self-protection when frightened or hurt. During the educational process, the therapist can describe the dissociated parts of the self with child-friendly language, such as “your feelings talking to you” or “your reminder voice about bad things that happened” (Silberg, in press). The therapist offers information about the “internal wisdom” of dissociation as a means of self-protection in times of danger but also emphasizes that dissociation can create problems in daily life when the feelings or states “pop out” and take over out of context and out of
the individual’s control. This begins discussion about a primary the goal of treatment, which is to lessen the use of dissociation, and sets the stage for collaborative work throughout the therapy.

The therapist and child, hopefully with the assistance of the parent or other caretaker, can start to identify those aspects of the child’s feelings or self that relate to past traumatic events, and recognize when they emerge in the present and seem to take over. For the child with DID, attention should be given to when a particular part came into being, what label or name the child has for the part, and its function within the child’s self-regulatory and self-protection system. The theme right from the beginning of therapy is not that dissociated feelings or parts are bad or should be eliminated or avoided but that the child needs to recognize and thank them for the help they gave during the time of trauma, listen to the feelings or distress they express or hold, and give them a new role (as helpful feelings or parts of the child’s self) within the safe (or safer) world in which the child is presently living. The therapist helps the child move toward increased self-awareness by asking him or her to “listen inside,” draw pictures, or write or talk to other parts of the self that have been identified and thus to accept them.

As the child, parent, and therapist identify when and how these parts of self or dissociative states developed and now emerge, they can start to identify the situations or feelings that trigger and elicit each particular state. Thus, a critical part of this first stage of therapy is the identification of triggers and then helping the child learn to separate a trigger associated with past traumatic event (e.g., an abuser raising his voice) from an event in the present that has similar elements (e.g., a teacher raising her voice). The differentiation of past from present and of danger from safety is emphasized and reinforced throughout the treatment. Throughout, the therapist needs to remember that, with the dissociative child, she or he may not be accessing in treatment the part(s) of the child that experienced the trauma. It is only when hidden parts of the child which feel and
react to the trauma of the past, perceive that ‘now’ is different, that the child can begin to truly feel safe. The therapist can invite the child to dialogue with dissociated states or express dissociated feelings, perhaps using drawings, play objects, or imagery, about the ‘now’ world. The bilateral stimulation in EMDR may be used with this work to support the processing of past traumas.

Another important aspect of the first stage of therapy is stabilization—of the child’s internal reactivity, and of the chaotic aspects of his or her world. Various methods can be used to help the child with identifying emotion and with regulating over-reactivity or dissociative shutdown. For example, the child can learn to breathe slowly and to use breath to counter reactivity. He or she can learn to distract and shift awareness with exercises such as standing on one foot, rolling on a gym ball, or wrapping up in a blanket. The therapist can inquire (e.g., “I wonder …”) how this feels for the scared or the angry part of him or her, and what the child is feeling physically and emotionally. Shifting the child’s attention to a dissociated part of the self or feeling helps the child to develop a more integrated central awareness (e.g., “What I am feeling that I hadn’t noticed”). Those experiences together with activities including music, movement and rhythm can enhance the child’s emotion regulation capacities (see Perry chapter, this volume).

As these activities are conducted with one or both parents (or other caregiver), attachment bonds can be strengthened, a very important part of stabilization and the reinforcement of safety. Encouraging parents to hold and rock or gently massage their child, to talk about feelings and body sensations, to find opportunities to feed him or her and to increase eye gazing between them can increase the child’s security of attachment while simultaneously developing the skills needed for emotion regulation. Particularly important is helping parents become attuned to the child’s experience and maintain their attunement as they interact with the child (Hughes, 2009). Although parents are encouraged to understand their child’s impaired self-awareness and
defensive use of dissociation, they also are encouraged to help their child take responsibility for age-appropriate actions even if the child believes those actions were controlled by another part of self. They can empathize with the child’s dilemma of being forced to take responsibility for something they don’t recall or didn’t feel they could control, and how frustrating that must be. This kind of support and help in establishing a position of integrated awareness and responsibility can, at once, reduce the child’s distress and sense of helplessness and encourage association and awareness, thus reducing dissociation. Behavioral programs can be used to reinforce access to memory of behaviors carried out by dissociated part(s). Silberg (in press) discusses a clinical case where a child earns access to an honors level program at school for remembering the destructive behavior he engaged in at home that he had become anmestic for due to dissociation. The child’s internal integration was facilitated by highlighting the child’s awareness of his destructive behavior even when he was not in his angry destructive state.

Stage one therapy also includes helping a child learn to get out of dissociative shut-down states that may be evoked by traumatic triggers within and outside of the treatment setting. Some children may become unresponsive (eyes closed, shallow or rhythmic breathing, rocking) and have difficulty being aroused when in these states. Since these states may be a form of altered consciousness and self-hypnosis, the therapist can use gentle hypnotic imagery to suggest moving into safety and then awakening ready to handle feelings in a new way. The therapist helps the child and family to identify the events or feelings (triggers) that precede the onset of these states in order for them to learn and practice new methods for handling feelings or solving what has seemed to the child to be irreconcilable conflicts or unacceptable emotions. They also are assisted in learning grounding skills to use with the child.
For many parents, the concept of dissociation is difficult to understand and accept. They may view their child as defiant, disobedient, unmotivated, selfish, unintelligent, or strange. Unfortunately, these labels or related diagnoses may have been used by professionals (i.e., oppositional defiant, attention deficit, hyperactive, bi-polar, or some other disorder). Attuning to the parents’ desperation and anger may be the hardest part of the therapist’s work with the child. Indeed, many of the parents (birth, foster, and adoptive) of children who dissociate may also be dissociative. As the therapist works with the parent, the therapist can discuss parent’s experiences that are similar to those of their child’s, especially with regard to unresolved trauma and loss. The therapist also can stress the importance of the parents addressing their own issues and, at times, help parents to make the decision to seek their own therapy.

While the family is usually the primary and most important system in which a child functions, he or she is in contact with other systems as well, such as school, church, community programs, or protective services. The therapist can play an important role in helping key members in other systems understand dissociation. Explaining the dynamics of dissociation and providing suggestions for teachers, legal, medical, school, or religious professionals, and other important adults in the child’s life can help to stabilize the child’s world and increase his sense of safety (Yehuda, 2011). Education related to dissociation for protective service workers not only means the child will experience more appropriate support from case or investigative workers because they will better understand how dissociation can block a child’s ability to disclose abuse or to maintain personal continuity (Waters, 2007; see Bloom chapter, this volume).

**Stage Two**

There is no clear line between stage one (safety) and stage two (trauma processing) in this treatment, particularly when working with children. During the first stage of work, as triggers are
identified and processed, there often is reference to the time of trauma and how the present is different from the past. As nightmares, intrusive thoughts, or flashbacks occur and are worked on through artwork, play, imagery, or conversation, bits of trauma are being processed. The strengthening of attachment relationships both in therapy and in the family helps promote the child’s self-regulation skills, allowing trauma processing to begin. The revisiting of trauma may temporarily destabilize the child, something all parties should know ahead of time. A return to phase one work with its emphasis on safety, stabilization and strengthening may be necessary and should be expected and not seen as a treatment failure.

Regardless of the therapist’s approach to treatment, attention to the dissociated feelings, sensations, cognitions, experiences and/or self-states of the child is essential for the child to reconnect with all aspects of the self. Dissociation-focused therapy can be integrated with any approach for processing trauma with children. For some children, trauma scenarios emerge within play, art, or their conversation, and the therapist can begin with gentle reflection or inquiry to encourage connection to the trauma-related and dissociated emotions, body sensations, or internalizations (Silberg, in press; Wieland, 1998, 2011). For others, therapist-introduced activities such as metaphoric play activities (Marks, 2011), hypnotic-type interventions (Grimmick, 2011), time-line narratives (Wieland, 2011), story-telling and “listening inside” (Silberg, 2011) can help the child process and become less phobic of all aspects of the trauma.

Moments of dissociation are likely during trauma processing. The child might deny the impact of the trauma (“I really didn’t mind what happened”), show a glazed or suddenly angry or scared look, or display a sudden body shift or voice tone change. Each of these manifestations needs to be recognized by the therapist and acknowledged in order for that dissociated feeling state
to be included within the therapeutic interaction. The therapist acknowledgement of all feelings helps the child welcome contradictions or inconsistencies in himself/herself.

Therapists without a clear understanding of dissociation are likely to respond to those moments of dissociation by immediately grounding the child back to the present. This grounding may be appropriate if there is a possibility of angry outbursts, anyone getting hurt, or the child being overwhelmed. However, if there is no such danger, the child’s dissociation can be used within the therapy. For example, the therapist can state, “I noticed a really scared look come in just briefly. What does that part of you want us to know or need from us now?” “What can you tell that part of you?” Whether through play, art, movement or discussion, the therapist can gently guide the child toward facing and reconnecting memories, emotions, body sensations, and/or behaviors that have been disconnected from the child’s central awareness. Simply re-grounding the child in the present may paradoxically serve to reinforce dissociative strategies, rather than allowing the integration of dissociated experiences.

While attention to dissociated feelings and self-states in therapy can be useful and productive, the child needs to learn that it is not a good idea to purposefully switch to other self-states as a means of avoiding or coping. For example, when anger is too overwhelming or appears at inappropriate times (during school, at the end of a therapy session), a therapist can assist the child to become grounded to the present (i.e., “Look at your hands: they are the hands of a 12-year-old, not a 2-year-old;” “Place your feet on the floor and push down with all the strength of a 12-year-old and feel yourself here in this room now.”). Then it is important to provide a link to this emotion or self-state (i.e., “Let the frightened you/the 2-year-old you know that we can look at that fright a little bit at a time/at our next session; we will connect with this feeling/this part of you
again and listen carefully to all that needs to be said;” “Can the 12 year old part of you look out through your eyes now and help you adjust to what you need to do now?”).

While explicit memories can often be addressed directly, implicit memories encoded in somatosensory form during the early years of life as the result of relational and other forms of trauma are often only partially accessible to conscious awareness. They may surface metaphorically through nightmares, repetitive or unusual play patterns, or art. They may be at the base of the child’s fears or seemingly innocuous questions. They may be expressed through behaviors that are destructive towards self or others, that are developmentally inappropriate or that are over-controlling. Therapists will need to be alert and sensitive to trauma indications in each of these areas. Making linkages and gentle inquiry between what the child does express—albeit non-verbally—and the early trauma is important. For example, the therapist might say, “I notice you holding the girl doll upside down over the edge of the doll house and it reminds me of the time your mother told me about when she saw your father holding you as a baby over the railing of the balcony. What would that have been like for the “little you?” By highlighting the past in this way within a safe supportive setting, the therapist is able to help the child experience not only the trauma but also the feelings, sensations and internalizations from the trauma and the realization that the trauma is in the past and has been survived. During all of this work, and particularly if and when new destructive behaviors emerge, the therapist needs to be alert to feelings or self-states that may still be hidden and that have not yet been revealed in therapy (Waters & Silberg, 1998a). Gentle inquiry (see Marks, 2011; Silberg, 2011, in press) can be used to evoke and support these dissociated states and allow safe forms of expression either verbally or non-verbally within the session.

Stage Three
Herman (1992) referred to the third stage of trauma therapy as “reconnecting with the world.” In dissociation-oriented treatment, this stage is often referred to as “integration and moving on.” Reconnection of the child and his or her dissociated states occurs bit by bit throughout the first two stages of therapy. Most children experience what is known as “spontaneous integration,” when parts of the self merge to the point where they are no longer perceived or experienced as separate. For children with more extreme dissociation, integration metaphors (ingredients mix together to make a delicious cake; soccer players work together to form a strong team) or rituals (all parts holding hands and walking towards and into each other) can be used to strengthen and re-enforce the concept of integration (Waters & Silberg, 1998). As in the earlier stages of therapy, the dissociation-informed therapist is alert for and comments on any instances of disconnection that occur. The therapist talks with the child and parent about times in the future when the child may again experience dissociation and ways the parent can assist the child in dealing with threatening experiences without disconnecting themselves or their experience from their central awareness.

**Working Clinically With a Child with Extreme Dissociation: The Case of Henri**

Henri, a 6-year-old Haitian boy adopted into a Canadian family with two children (a girl of 9 and a boy of 6), strode into the therapist’s (SW) office with a very “take-charge” attitude. His adoptive mom had briefly explained his history in a Haitian orphanage that included malnutrition, physical and sexual abuse, witnessing adults and children being killed, all capped off by the 2010 earthquake. Over his years in the orphanage, he had been visited from time to time by his birth parents who had placed him there at 20 months of age due to their poverty. His adoptive Mom explained that over the past year in Canada, Henri often and suddenly become very angry and aggressive, making threats such as cutting his brother’s head off. In contrast, when
he was scared, he curled up and cried like an infant. At some points, he hit his head on hard objects and at others he closed down and would not talk to anyone. Although he stated that he wanted friends, he was often quite intimidating when with other children. These changes in behavior, the extreme levels of dangerous and frightened behavior, and the observed regression suggested that dissociation. The adoptive parents completed the Child Dissociative Checklist (Peterson & Putnam, 1994) and the score of 20 was highly consistent with a dissociative disorder.

His completion of the House, Tree, Person Projective Test (Buck, 1970) suggested that Henri had little sense of family and experienced contradictions within his world. For a house, he drew the therapist’s office building, for a tree he drew an apple tree that was “healthy” but that had no apples drawn on it, and for people he drew children who were “super-happy” but had no friends.

Following an assessment session, the first series of interventions included psycho-education and preparing the child and family for the treatment. SW talked with both Henri and his parents about dissociation and how children use it to protect themselves when in conditions of threat and danger. SW explained that although certainly a part of Henri knew he was safe in Canada, there were probably many parts of him that he had split-off in order to survive past experiences and that those parts, because they were connected to the past, would not automatically know about the safety of the present. SW emphasized how both she and the parents would need to work together to help all the parts of Henri realize that he was now safe. SW also talked about how Henri’s internal system—his brain and his body—would not have had enough calming and soothing experiences during those years in Haiti and how he might need more of the holding, rocking, rhythmic, and feeding activities of the sort they had given to their other children when they were young—while cautioning that these needed to be done in ways that were comfortable and acceptable to six-year-old Henri. Such explanations help parents learn about
dissociation and also emphasize how important their role is in the therapeutic process and in reversing the automatic use of dissociation.

The next goal was to work on stabilizing Henri’s behavior throughout the day. As Henri created a volcano in the sand tray, his mother discussed his agitation at bedtime when he talks about his bad memories of Haiti. SW suggested they find another time of day for Henri to talk about them and for Mom to create a box (either real or imaginary) with a lock where Henri could put his disclosed memories. As Mom locked the box, she could remind Henri that of his present-day safety in Canada and ask him to tell “the part of him that lived through the bad memories in Haiti” that he is now safe in a new family and new country. Then for bedtime, SW suggested that Mom create a song about Henri coming to Canada and doing safe things with his new family. SW also suggested engaging in some rhythmic activity after locking the box and utilizing a body massage at bedtime to help settle Henri.

These early interventions did not cause much change in Henri’s “nasty” behavior at home. Henri continued being particularly nasty to his mother whenever she said “no” to something he wanted, telling her she was not keeping him safe and putting her down in front of others. SW suggested whenever possible Mom sit with Henri after such behavior—first stating his name and her name and that he was safe with her; then naming his anger at her and wondering if the anger was because she was not there when he had had to go to the orphanage, an unsafe and scary place, and that she wishes she had been able to bring him to Canada then. She should emphasize that he is now safe and that even the “angry him” is safe. Mom was particularly concerned that Henri’s nasty and threatening behavior happened whenever she said ‘no’ to him and that he was trying to manipulate her to get his own way. SW explained that, because of past trauma, Henri’s nervous system was in continual high arousal and he was on “high alert.” Most
children get upset or frustrated (i.e., their stress arousal system goes up but stays within a manageable range) when their requests or demands are refused. For Henri, already in high arousal, the upset would put him over the top of the manageable range and out of control. The ‘out-of-control’ feeling probably was a trigger for old experiences and resulting dissociation to the point of switching to another state. SW suggested that before she refuses requests or disciplines him for negative behavior, Mom talk to him quietly to remind him where he is and that he is safe. Calming and grounding need to happen prior to discussion of the event. Whatever regular consequences the parents use to curb negative behavior should then be used to communicate to Henri that he is responsible for all his behavior in the present, even behavior that he cannot remember engaging in (possibly due to dissociative amnesia). In this way, he is encouraged and reinforced in learning that all parts of him are responsible for his behavior.

Attuning to the child’s anger is an important part of connecting with him or her. Once again the emphasis is that all parts of Henri are acceptable as are all of his emotions. Because children who are dissociating often ‘erupt’ when they are made to do something they do not want to, parents often experience them as manipulative—and, indeed, they seem manipulative. Explaining how trauma creates a state of hyper-arousal and reactivity within the child’s nervous system can help the parent understand and not feel as threatened or as manipulated by the child.

The next important step is to help Henri recognize that he can accept and be grateful to the many parts of himself and to start exploring the angry, hateful feelings that he has been expressing. A few sessions later, Mom brought in a picture Henri had drawn of himself with two sets of eyes, one set that loved mom, and another set (“the inside eyes”) that hated her. SW asked when he noticed the ‘hating Mom feeling’ and he said when she tells him ‘no’ or tells him to go take a bath or do things he did not want to do. SW noted how important that ‘hating feeling’ was—
how that feeling had helped him hate (and not take in) the bad things that happened in Haiti. SW suggested that Henri and Mom could thank the “hating part” for helping Henri during his time in Haiti. Then SW asked if the ‘hating part’ knew he was safe now. Henri started talking about seeing people getting beaten and killed when he was in Haiti. SW thanked him for telling her about that. Although Henri had moved into doing some trauma processing, SW did not feel that enough work had been done on Stage One safety and stabilization to move further into that area.

SW continued psychoeducation with Henri and his parents about accepting his “angry parts” and feeling. When he came in and picked up the foam bat and started hitting the large gym ball (SW had explained to him before that the bat could be used for expressing anger in a safe way), SW asked if he had been angry during the week. Henri replied, “No.” When SW asked Mom, she told about his banging doors and also banging his head against the wall. When SW asked Henri if he remembered that, he nodded but she noted that he was staring with a blank look in his eyes. SW picked up a play tree trunk that has six small animals inside it and noted that people are the tree trunk with many different feelings or parts inside (Any toy or doll with multiple parts can be helpful when explaining dissociation to children). When frightening things happen, feelings like fear and anger can get so large they cannot be kept inside but they get shoved out when it is not safe to express them. Doing so makes it hard because the anger is “on its own” and doesn’t have the “thinking part” to help it. SW asked Henri which animal would be the angry part of him. He pulled out the tiger and SW asked what that part would say. Henri did not reply but Mom mentioned that he talked everyday about killing people and that his threats scare the other children in their family. At this point Henri was lying on his stomach over the gym ball. SW gently moved the ball back and forth and said, “So much happened in Haiti, so much killing happened in Haiti, what happened there was really scary but doesn’t happen here in
Canada. Can you tell the “angry Henri” and the “little scared Henri” that it doesn’t happen here, now?” SW suggested that Mom and Henri thank the “angry Henri” for helping him survive in Haiti and that perhaps the “angry Henri” could have a new job rather than that of threatening to hurt people. The movement of the ball helped provide calming for Henri’s physiological system, thus helping Henri connect to what was being said.

The next week, Mom reported that displays of anger and talk of killing had receded as they thanked the angry part of Henri. She and Henri, however, had not been able to come up with a new job for the angry part. Mom explained that she had told the children that Dad’s mother was very sick and had asked them not to talk to Dad about it. Henri had immediately gone to Dad and talked to him about grandma, all the time having a grin on his face. SW asked Henri what this was like for him, having grandma so sick--she wondered if he was feeling sad like he did when he lost his birth family and angry that he might lose someone else. Henri picked up the trunk with animals. SW noted that lots of different feelings would have come up and asked which would be the angry feelings (Henri pulled out the tiger), the sad feelings (Henri pulled out the raccoon). Henri then picked up the crocodile puppet and had the crocodile ask Mom why he did not have front teeth. SW noticed the crocodile asking questions and wondered if the angry part’s new job could be to ask questions. Finding a new job for negative feeling parts allows the child to integrate that part rather than trying to control or get rid of it. When working with young children, their play often tells us what will be useful. With older children, asking them for their ideas is helpful.

Henri’s behavior improved considerably during the following weeks. Mom reported that he was asking lots of questions. Dad came to the session with Henri and talked about Henri not taking responsibility for his negative behavior. When his brother would ask Henri to stop teasing
and chasing him, Henri would insist that he was just playing and deny doing anything wrong. Henri clearly remembered this behavior so it did not appear to be dissociative—possibly, it involved a lack of understanding on his part. More likely, Henri had wanted people to stop doing what they were doing to him in Haiti but no one had stopped. SW set up a game of ball between Henri and Dad and had Henri call out “stop” from time to time. Dad would immediately stop. SW asked them to continue this game at home as it allowed Henri to experience being noticed, heard, and responded to. He had power in a positive way which helped him combat the helplessness he felt previously. When working with children who dissociate, it is important to remember that all negative behavior is not a result of dissociation. Learning alternative and healthier behaviors and developing empathy for self and others are important parts of the therapy.

In a later session, when Henri was creating objects out of plasticine, SW asked him what he was making. Henri showed her a ball with a face on it saying that it was Henri. SW asked about the marks on the other side and he said that was the robot. Henri explained that the robot took over his body when Mom said he couldn’t do something, and that it was the robot who teased his brother. SW noted, “Yes, different parts, but just like they are both on the ball, they are both you and you are responsible for whatever any part of you does.” Two weeks later, Mom said that Henri was not teasing as much but was demanding things in a very nasty voice. SW asked about the plasticine ball. Henri found it but the face part could not be seen. Henri redid the face as SW talked about how all the parts could work together to not be nasty. Henri said, “It is like a team,” and he and SW talked about how players on a team need to work together to win a game.

In time, Henri’s behavior settled considerably, enough to begin more direct processing of the trauma. Although bits of the trauma had come up during the first stage of therapy as Henri talked about memories and nightmares, considerable abuse and detail had not been disclosed nor discussed.
Mom and SW met to review what was known about Henri’s past. SW then created a story of Henri’s early years – early months in a caring family but without enough food, being left at the orphanage, sexual and physical abuse at the orphanage, being burned with cigarettes and hit with sticks, witnessing a child getting killed, experiencing the earthquake, being taken away and put onto a plane, and finally being met by strange people speaking a strange language who were to become his new family. For each trauma segment in the story, SW outlined the likely associated feelings and thoughts and the physical sensations Henri would likely have experienced (adaptation of the story timeline used by J. Lovett, 2004). After processing each trauma segment, SW included a positive element (e.g., his body still being healthy, not being killed). Since it was not possible (or advisable) to review the whole story in one session, it was important to give Henri to a sense of survival, safety, and hope at the end of each session. SW read the story of the negative experiences, adding the likely feelings, thoughts and sensations. After each segment, SW asked Henri to play out what happened in the sand tray, draw a picture of it, and imagine it to encourage exposure to and processing of the experience. Mom, as Henri’s safe person, then read about the positive elements.

The next week, SW started the session by reading the story about when Henri was left at the orphanage and his witnessing a baby getting seriously hurt, on his very first night there. As SW read about fear and thoughts that something bad might happen to him, Henri’s mouth curled up. SW validated that his fear in the present was coming up from what had happened to him back then. SW mentioned the frozen body feelings that he likely would have had and Henri stood very still. After SW, and then Mom, finished reading their parts, SW asked Henri what he would like tell the “little him” through drawing, using the puppets, or using the figures in the sand tray about what had happened. Henri stood completely still at the sand tray and did not answer. SW opened the cupboards with the miniatures. She took out a little child figure and Henri took out the baby.
He then chose soldiers with guns and lined them up on the edge of the sand tray. “They’re shooting! The baby’s running!” SW noted that there was not a plane among the miniatures and that one was needed to take the baby to Canada. Henri reached in the cupboard and took out the dragon, and placing the baby on the dragon’s back, he flew the dragon to Mom who took the baby in her hands and told the soldiers they could not come to Canada. Henri took out the superman figure, put him in the sand tray while saying that he was dirty and then cleaning him off. SW asked the superman figure to tell the baby that what happened is Haiti was over and that he is now safe, which he did. Henri then went over to Mom and said he wanted to make a rainbow with markers. He labeled the black marker as angry and the brown one as bored (a word sometimes used for a dissociative state) and wanted to throw out those two markers. SW noted that they needed to keep them along with all the other feelings because they were very important and when they were with the other colors/feelings they would not take over completely, so they and Henri could be safe. When SW noted that it was almost the end of the session, Henri went over to the sand tray, climbed inside on top of the sand and curled up (his feet over the edge because he was too big to fit) and closed his eyes. “Yes, the baby Henri is safe here,” SW said and mentioned the end of the session again but there was no response. Mom asked him if he would like her to carry him, no response. Mom picked Henri up and carried him out – his eyes never opened.

The trauma processing with Henri was similar to what would have occurred with other trauma-focused therapies—feelings, thoughts, and body sensations were included and then present safety was emphasized at the end. Dissociation-focused therapy allowed Henri and all of the younger parts of himself to know that the bad experiences of Haiti were over and that he was now safe. Attention to all feelings including those that are negative (represented by the black and brown markers) was important. Henri’s climbing into the sand tray at the end of the session
signified that the younger part of him was there and was absorbing a sense of safety. Mom’s acceptance of and response to Henri’s behavior enabled him to experience the present safety and security as both the 6-year-old and as the dissociated regressed part of himself. Mom reported that Henri was very agitated and hyperactive the afternoon after this session but settled down afterwards and did well over the weekend.

The next week Henri came in asking why he had to come to therapy, while his brother did not. Mom stated that therapy was to help him to get better after all that had happened in Haiti. Henri went over to the doctor’s kit and took out the stethoscope. He listened to his heart and then placed it on his forehead. SW asked if he was listening to the robot. Henri asked, “What robot?” and SW reminded him of the robot he had made on the plasticine ball that he had identified as the part of him that didn’t do what Mom asked. Henri said that he could not hear any voice in his brain. SW mentioned that they were going to be continuing to talk about his story. At that, Henri again climbed into the sand tray but this time lay on his back rather than curling up. Mom and SW put a pillow under his head. Henri picked up handfuls of sand and let them run through his hand during the part of the story where the children were hurt at the orphanage. As SW read, Henri started talking about being hurt, not liking being hit, trying to make good choices but being forced to make bad ones. In the story, SW talked about Henri being so scared and so angry that he had had to not feel those feelings when he was being physically hurt in order to keep himself safe. Henri showed the place on his leg where he had been burned and SW switched to that part of the story. The story ended with Mom reading to him about being in Canada and his body being healthy now. Henri climbed out of the sand tray and picked up an empty baby bottle from a collection of toy objects. As he pretended to drink from the bottle, SW talked about him letting the “baby him” know that he was now safe and in a new country. Henri talked about having had a
bottle when he first came to Canada and how he had shared it with his Canadian brother. When SW noted that it was time to stop, Henri went over to the couch, climbed up, stretched out, and fell asleep—again Mom carried him out. Henri’s report of having no voices in his head indicated a decrease in his dissociation. Henri’s letting the sand run through his fingers was an indication of an increase in emotional calming skills. Further, Henri engaged in the story, calmed himself with the bottle, and then linked the bottle to his early time in Canada. His falling asleep on this day was like the behavior of a toddler, rather than that of an infant.

Over the following weeks, the review of Henri’s life story continued, always ending with an emphasis on the safety of his life in Canada. He continued to find activities that engaged the younger parts of him. Sometimes SW would approach activities by asking, ”How can we tell the ‘baby you’ about this?” and, at times, Henri directed the activity as he did with choosing the bottle. Following these sessions, his behavior would be agitated for a day or so but then he would calm down. For Henri, the third stage of therapy – integration of the trauma and moving on—seemed to occur spontaneously. His hostility toward Mom settled and his intimidating behavior towards others decreased and then disappeared. He would look at SW quizzically when she asked about the robot or the part that sometimes made bad choices. He seemed to find it entirely natural that he had a fully integrated set of feelings, thoughts, and actions, no longer split up into parts.

**Conclusion**

As the case of Henri illustrates, dissociation-focused therapy for children and adolescents with complex trauma histories begins with assessment and education about dissociation for the child and parent(s), in order to help them gain greater awareness and acceptance of the child’s split off or fragmented emotions and self states. During trauma memory processing in Stage 2, the monitoring and incorporating of dissociated emotions and self states enables the therapist to help
the child to develop an affective and cognitive understanding of past traumatic experiences and an increasingly integrated sense of self. This facilitates Stage 3 resolution of distressing emotion states and the resumption of healthy integrated psychosocial development. Addressing dissociation in any child psychotherapy model thus provides a basis for fostering the reintegration of split off affects and self states as well as the resolution of other sequelae of the exposure to and experiencing of complex traumatic stressors.
References


