DISSOCIATION IN CHILDREN AND ADOLESCENTS: FREQUENTLY ASKED QUESTIONS BY PARENTS

Prepared by the Child and Adolescent Committee of ISSTD

(Note: *These questions and answers are designed to assist parents in understanding dissociation. Consultation with a professional is necessary for a thorough and accurate evaluation. For ease of reading, "child" (meaning child or adolescent) will be used in the answers below, and the use of "he" and "she" will alternate).*

1. My child's behavior and mood can suddenly change like Dr. Jekyll and Mr. Hyde. I heard about dissociation and wonder if this is what it means?
2. What would cause my child to dissociate?
3. How might my child behave if she is dissociating?
4. I've read and seen movies about dissociation, especially Multiple Personality Disorder, in adults. Are children like that?
5. My child seems to have symptoms of dissociation but has been given many diagnoses: ODD (Oppositional Defiant Disorder), ADHD (Attention Deficit Hyperactivity Disorder), and even Bipolar Disorder. What should I do? Should I pursue this further?
6. Do these symptoms mean that my child was sexually abused?
7. Can my child get better?
8. What should I do now?

1. **My child's behavior and mood can suddenly change like Dr. Jekyll and Mr. Hyde. I heard about dissociation and wonder if this is what it means?**

Normal Dissociation:

Before answering this question, a description of dissociation would be helpful, in many instances dissociation can be considered normal or non-problematic. Here are some examples:

- A child becomes completely absorbed in an activity and then is not aware of what is around him (e.g., when playing a video game).
- A child develops "a make believe world," but knows the difference between what fantasy is and what is real.
- A child (even an adult) can read to the end of a page and not know what he has read because his mind has gone somewhere else.
- A child can block out something unpleasant (for example, a painful injury), without harming his overall functioning.

These instances of normal dissociation do not interfere with the child's development and social and academic progress.

Problematic Dissociation:

Another type of dissociation, that is the focus of this website, is called "problematic dissociation" or "pathological dissociation". As with other difficulties that people have, there is a **continuum or a degree of seriousness of dissociation.** Problematic dissociation can be considered mild, moderate or severe, depending on many factors described below. Children can experience varying degrees of dissociation at different times.

Problematic or pathological dissociation can occur when a child has to cope with an overwhelming or frightening event, with multiple frightening events, or with a confusing living situation (see FAQ 2 below). The child feels very afraid and helpless and cannot escape from the situation. He may even fear that he will not survive. To cope with this, he finds a way to 'escape' by blocking off (dissociating) the terrifying event(s) from his memory, by blocking off feelings of pain, hurt, and rage, and by blocking off bad thoughts about himself and those hurting him. He may go into a trance state or 'space out' (zone out, go blank, or shut down) and not be aware of his surroundings. This is a survival technique used at the time of the frightening event and can be helpful to the child at the time. However, this 'zoning out' may continue to happen in other circumstances, which may keep the child from developing normally – meeting social and academic expectations, appropriately managing emotions, and forming healthy attachments.

Young children are more prone to dissociation than older children because they don't have the abilities to manage what is frightening or painful and can't remove themselves from the situation. However, the way each child handles such a situation will depend on many factors. Some factors may be, a) the child's ability to calm himself and to believe his world can become safe again; b) the parent's ability to listen to the child's confusing and conflicting feelings, and openly discuss the traumatic situation; c) the availability of prompt, appropriate and supportive services for the child and parent.

Mild Dissociation:

An example of a mild form of dissociation might be when a child is at school and is 'spacing out' and not listening or attending to the teacher, without having control over this behavior. This can interfere with his overall learning and development, particularly if it happens often.

Moderate Dissociation:

A moderate form of dissociation occurs when a child has developed the skill to not feel his body being hurt, for example, during physical or sexual abuse, or medical interventions. This is called "depersonalization"- a person feels numb or doesn't feel his own body. He may be able to block out other senses as well, like hearing, tasting, and seeing, which can affect his ability to learn. The continued use of dissociation can keep him from being aware of his bodily sensations and functions. For example, children who have numbed their bodies may not know when they hurt themselves because they can't feel the pain. They may not respond the way we usually expect children to respond to pain, illness or harm, and their injuries or illnesses might be missed or minimized.

Another moderate form of dissociation happens when a child must separate himself (his conscious awareness) from his surroundings to avoid experiencing the terrifying event. He develops the skill to not be aware of what is going on around him or to make what is happening to him feel unreal. This is called 'derealization' – the feeling that present surroundings seem unfamiliar or unreal in some way. This may happen during the terrifying event and it can reoccur when things remind him of the original situation.

Severe Dissociation:

Dissociation at the far end of the continuum happens when the child, in order to escape a terrifying event, has to separate so completely from himself that it feels as if separate selves hold the awful feelings, thoughts and memories. These are called "dissociative parts" (also referred to as "dissociative states"). The child is still one *individual*, but he experiences separate parts of himself with separate awareness or "consciousness". These parts of the child can hold the unwanted and unacceptable feelings, thoughts, and frightening memories away from the child's ongoing awareness so he doesn't experience them. Otherwise, it would be too hard to go about his daily life and do what is expected of him. This type of dissociation can be understood as a disturbance or disruption in his identity: the child feels as though he has separate parts or states of awareness rather than the single self that includes all feelings, thoughts and behaviors.

A child's dissociative parts can influence the way the child behaves, feels, thinks, or remembers. Sometimes, he truly may not be aware of what he has done or experienced. To others, it may look as though he is lying. This is called "amnesia", an inability to recall important information about present or past behavior or events. The child may hear voices inside his head, such as an "angry part" yelling at him or a "helper part" telling him how to behave. He may or may not give the voices names of people, animals, toys, or feelings. However, these parts do not take control over the child's behavior and do not present themselves to others; they remain inside the child's mind. This is called "Other Specified Dissociative Disorder". (Formerly called Dissociative Disorder Not Otherwise Specified).

The most extreme form of dissociation occurs if these dissociative parts completely control the child's behavior. The child presents to others as if he is different people at different times. This happens when the separate parts control both his behavior and his awareness. This is called "Dissociative Identity Disorder". These shifting parts are very confusing to the child and to those around him. He may have considered periods of amnesia during these times.

It is important to keep in mind that dissociation is an adaptive response to an abnormal situation. It is creative and helpful when a child cannot physically escape a terrifying, painful situation. However, it can become a pattern of responding even when it is no longer necessary. Such a pattern of response can cause serious problems for a child at home, at school and in relationships (see FAQ 3 below).

Conclusion:

Developing a comprehensive picture of your child with the help of a knowledge professional will determine if your child has dissociation or if his behavior is due to some other reason. See FAQ 3 for further symptoms that relate to dissociation.

2. What would cause my child to dissociate?

Children, like adults, dissociate when they are overwhelmed by fear or pain, feel helpless, and cannot escape. They block out what is happening to them and what they are feeling.

Below is a list of the types of situations that may cause a child to dissociate:

- Physical abuse
- Sexual abuse
- Emotional abuse (yelling, screaming, exploitation, and/or critical, demeaning statements)
- Chronic neglect (repeatedly ignoring the child's physical and/or emotional needs)
- Witnessing family violence or street violence
- Violent or repeated loss of loved ones (including abduction/kidnapping of the child)
- **Being cared for by frightened or frightening parents**

- Physical injury, painful medical conditions and procedures (e.g., burns, cancer)
- Frightening and painful accidents
- Being in or witnessing a natural disaster (e.g., earthquake, flood)
- Repeated separation from the person who takes care of the child and gives him emotional support
- **Severe and chronic bullying**

It is important to remember that, if your child receives support and feels safe soon after a frightening event, any dissociation may be temporary and, therefore, not problematic.

3. How might my child behave if she is dissociating?

Dissociation can show up in many different ways. You may notice sudden, changes in your child's behavior, feelings and/or attitudes. Sometimes these shifts happen many times in a day and sometimes they happen less often. Your child may not be able to explain why she is behaving this way. She may not even know that her behavior changes. Below are several lists of changes in behavior, emotions, thinking, and physical conditions that can occur in dissociation. As you read these lists, remember that not every child will show all of these signs or symptoms. Some signs may be mild while others may be very intense.

REMEMBER, many of these symptoms can occur with problems other than dissociation. *It is the combination of many symptoms that may suggest dissociation.*

Behavior shifts that are most commonly seen by parents or teachers:

a. Your child may act very grown up one moment and then behave like a much younger child (even a baby) at another moment
b. Your child may be aggressive and mean at one point and then become passive, loving, or caretaking at another time.
c. Your child may talk about herself with different names or may refer to herself as "we"
d. Your child may use different voices or specific mannerisms (for example, picking at her skin) at one time and not other times
e. Your child may want to wear her favorite outfit or eat her favorite food, but then later on, or perhaps the next day, she will say she hates the outfit or food. She may not be able to explain this change and may say she never liked the outfit or food.
f. Your child may have certain skills or be able to do certain activities easily and well (handwriting, sports, math, reading), but then, the next day, may have trouble with them or no longer know how to do them.
g. Your child may seem to 'space out' at home, school, or social events, and not know what is going on around her. Time may pass and she doesn't know what happened during that time.
h. Your child's facial expression may change dramatically and suddenly from smiling to angry without any apparent reason.
i. Your child's eyes may appear to be in a dead stare when you are talking to her (like she is miles away) or she may have a glazed look, particularly when she is aggressive or raging.
j. Your child may find herself in a place and not know how she got there. For example, she may be sent to the principal's office for misbehaving and not remember leaving the classroom, walking to the office, or even why she is there.

Emotionally your child may experience sudden shifts and move from one extreme feeling to a completely different or opposite feeling without showing any of the in-between emotions. The reason for this change in emotion may not be clear or make sense to you.

k. Your child may be calm one moment and then in the next moment become explosive, aggressive, frightened, tearful, or panicky.
l. Your child may show emotions that do not fit what is happening, such as laughing during a sad and upsetting situation or becoming sad or angry in a joyful situation.
m. Your child may not show any feelings at all. She may not be aware of any feelings.

Cognitive shifts may also be noticed by you. These are sudden changes in and sometimes contradictory ways of thinking.

n. Your child may be able to do an assignment quite well on one day, but then not know how to do the same or similar assignment the next day. Without any additional teaching, she may be able to do the assignment again later.
o. Your child may make a good choice when faced with a problem, but when faced with the same problem later on, she may make a poor choice and not recall the earlier situation and the earlier decision.
p. Your child may think that a completely safe situation is extremely unsafe and be very fearful. Or she may interpret an unsafe situation as safe.
q. Your child may not be able to recall important events, such as birthdays, holidays, family vacations, or camping trips.
r. Your child may have no memory of having done something even when someone saw her do it.
s. Your child may 'hear' voices inside her head. (Children seldom talk about this unless directly asked.)
t. Your child may report having 'inside people' that say mean things and boss her around. These are different from the pretend or imaginary friends that young children commonly have and outgrow.
u. Your child may think badly about herself (perhaps even feel suicidal) and see the world as a frightening, threatening place. Then suddenly she may feel good about herself and the world, and hopeful about the future.
v. Your child may have flashbacks (reliving a traumatic event) and be unaware of her present surroundings.

Physical or bodily changes may also occur for your child. Your doctor may not be able to find a medical problem or cause for your child's physical pain or difficulties. These physical problems may be a result of the tension or anxiety from a trauma that is being 'held' (remembered unconsciously) in the body.

w. Your child may wet or soil without knowing it is happening. She may not feel or smell it.
x. Your child may get hurt (for example, get a cut or break a bone) or may harm herself (for example, cutting or burning) and not feel the pain or be aware that she has been hurt.
y. Your child may have stomachaches, headaches, seizure-like motions, or other physical problems (for example, difficulty breathing, walking, genital pain) that cannot be physically explained.

Note: The above symptoms may occur only a few times a year or may be much more frequent and occur several times a day.

4. **I've read and seen movies about dissociation, especially Multiple Personality Disorder, in adults. Are children like that?**

Dissociation is not as obvious in children as it is in adults. As described in FAQ 1, Multiple Personality Disorder, which is now called Dissociative Identity Disorder (DID), is an extreme form of dissociation in which the individual's sense of identity has separated into states or parts that may not always be aware of each other. Most children and adults will experience less extreme dissociation.

Because the child is young, his dissociative states haven't had as much time to develop distinct characteristics or traits. Therefore, they are less obvious and noticeable than those of adults. Also, many children's dissociative states may be closer to the age of the child (compared to a child part in an adult) which makes the dissociation more difficult to notice. One part of the child may behave like a baby or toddler, while another dissociative part may behave much older and expected to be treated as an older person.

The good news is that since a child's dissociative states are not as well developed as those of adults, the separations between them are not as strong. A child can more easily become aware of the parts of himself, and any amnesia (memory problem) he may have can be more readily resolved.

Here is a list of some differences in child dissociative states compared to adult dissociative states:

- Changes in voice, mannerism, and moods in children are less dramatic than they are in adults.
- Inattentiveness (see FAQ 3 above) or trance states (see FAQ 3-g above) in child are often brief and less noticeable, and they are frequently thought to be attention problems.
- A child may not understand that the voices or 'inside people' he sees in his mind are unusual. A child may also feel afraid or embarrassed to talk about them if they are frightening to him.
- Aggressive or sexualized behaviors, including self-harming, which may occur in a dissociated state, are usually less serious than those perpetrated by adults.

5. **My child seems to have symptoms of dissociation but has been given many diagnoses: ODD (Oppositional Defiant Disorder), ADHD (Attention Deficit Hyperactivity Disorder), and even Bipolar Disorder. What should I do? Should I pursue this further?**

Many health professionals have not received adequate training in the field of trauma and dissociation. Recognition of trauma and its effects, including dissociative features, are all too often overlooked in the diagnosis of childhood problems. Doctors and other clinicians may focus on the most noticeable behavior rather than look at the total picture of a traumatized child.

For example, a clinician may describe a child as having a better known problem such as Attention-Deficit/Hyperactivity Disorder [ADHD] (www.cdc.gov/ncbdd/adhd/symptom.htm) because of problems with inattention. Or a child may be diagnosed with Oppositional Defiant Disorder (www.emedicine.com/PED/topic2791.htm) because of angry, uncontrollable outbursts.

As a child gets older and continues to be explosive, destructive and aggressive, he may be labeled with a Conduct Disorder.

A child with difficulties with memory and learning (see FAQ 3-n, 3-r, and 3-s above) may be labeled with a Learning Disability or Language Disorder. Children's fluctuations in behavior, feeling, and thought (see FAQ 3 above) may be seen as moodiness or as an adjustment problem related to changes in the environment.

If traumatized children have extreme shifts in behavior, feeling, and thought, they may be incorrectly diagnosed with Bipolar Disorder. Bipolar Disorder includes shifts in behavior and mood, but the shifts don't occur as frequently (for example, back and forth in a day) as they do in dissociative children. Another important difference is that in Bipolar Disorder (http://www.bipolar.com/index/html) there isn't the blocking of awareness, feelings or memories (amnesia) that is seen in dissociation.

There may be another reason why children receive other diagnoses when they exhibit dissociative symptoms. Because even clinicians do not like to think of children as being hurt, it is easier to talk about a child as angry and oppositional (Oppositional Defiant Disorder), or explosive (Conduct Disorder), or reacting to the pain of a severe medical condition, than it is to talk about (or think about) children as traumatized and dissociative (Dissociative Disorder).

Parents quite naturally do not want to think about trauma and its effects on their children. They may prefer to think that what happened wasn't so bad. They may believe that the child was too young to remember and therefore it couldn't affect him now. Or they may think that the experience is in the past and best left alone. Unfortunately, even if the trauma is not consciously remembered it may still have considerable effects on a child's mood and behavior – it may still be held within the mind and felt within the body.

It is not uncommon for foster and adoptive parents to have incomplete information about the child's history, and thus not report trauma when an assessment is being made. If the trauma is recognized, Posttraumatic Stress Disorder (PTSD) [www.nctsn.org] may be diagnosed but the occurrence of dissociation with the PTSD is minimized.

It is very important that you tell the doctor or mental health professional treating your child about any trauma (see FAQ 2 above), even traumas during infancy. You should also tell the doctor or therapist about any strange behaviors and, in particular, about shifting behaviors (see FAQ 3 above) you have noticed in your child.

****If a dissociative child is misdiagnosed, he will not receive the treatment he needs.** Treatment for non-attentive behaviors within a Dissociation Disorder is quite different from treatment for non-attentive behaviors within an Attention Deficit Disorder. **Accurate diagnosis is crucial!**

- If you do not feel that the diagnosis your child has received is accurate, you have a right to question the diagnosis and ask for a second opinion.
- If the treatment your child is receiving is not helping, you have a right to ask the professional to consider other possibilities, such as dissociation.
- Unfortunately, many children with dissociation receive numerous diagnoses and are treated with a variety of medications and unsuccessful therapies over several years before their dissociation is diagnosed and treated!

There are checklists that can help clinicians in the diagnostic process. Interviews, observations, history gathering, and contact with outside resources (school, daycare, medical) can also help to identify dissociation in children. You may want to ask your doctor or mental health professional about these checklists:

- Children's Dissociative Experiences Scale and Posttraumatic Symptom Inventory [CDES/PTSI], (Stolbach and colleagues, 1997; contact bstolbach@larabida.org).
- Adolescent Dissociative Experiences Scale, version 2 [A-DES, II], (Armstrong and colleagues).
- Adolescent Multi-Dimensional Inventory of Dissociation [A-MID], (Dell).
- Child Dissociative Checklist [CDC-III], (Putnam and colleagues).

6. Do these symptoms mean that my child was sexually abused?

Although many children with dissociation have been sexually abused, it does not mean that every dissociative child has been sexually abused. Remember, physical abuse, domestic violence, neglect, painful medical conditions, natural disasters and other traumas can also cause dissociation. Please refer to the above list in FAQ 2 for other causes of dissociation.

Determining if your child was sexually abused should be based on:

- Disclosures of abuse
- Behaviors of fear and other behavioral changes when faced with an alleged abuser
- Sexual knowledge beyond what is normal for the child's age
- Sexualized behaviors that are harmful or intrusive to himself or someone else
- Careful forensic evaluation by a trained professional

Referral to the local child protection service or social service agency should be made if you have concerns that your child has been sexually abused. In addition, a qualified mental health evaluator or therapist/counsel can be consulted.

For additional information:

http://www.aacap.org/page.ww?section=Facts+for+Families&name=Child+Sexual+Abuse

http://www.nim.nih.gov/medineplus/childsexualabuse.html

7. Can my child get better?

Yes! All levels of dissociation respond well to specialized treatment, particularly if there is early diagnosis and intervention, and the child is in a safe environment.

The professional working with your child will:

- Evaluate safety both in and outside the home. Safety is essential for successful treatment.
- Educate the child's caregiver(s) about dissociative symptoms and their meaning, as well as how best to intervene when symptoms occur.
- Address the problematic behaviors that are interfering with your child's functioning.
- Help your child process past losses or disruptions and develop a healthy attachment relationship with you
- Create with your child an integrated narrative (the story of the child's experiences – be it a single trauma or many long-term traumas – which includes the child's feelings, thoughts, and physical sensations together with information about the actual events(s) through talking, playing, writing, drawing, and attending to bodily responses.
- Encourage integration of the different aspects of the child's personality, experiences (memories), feelings or sensations that have been previously blocked from the child's total awareness.
- Coordinate with the family, school and others in your child's life to support your child's progress.

During each step in therapy your child's therapist will take note of dissociative signs and behaviors and work with your child to become more aware of her or his whole self.

You will also be involved in the treatment. **The single most important part of healing from trauma-related distress and dissociative barriers is the safe, loving attachment relationship you create with your child.

8. What should I do now?

First of all, congratulate yourself on taking the initiative to do the research and reading that you are doing right now. And second, remember that dissociation is treatable.

You will want to learn as much as possible about dissociation. Information about dissociation can come from therapists, social workers, psychologists, school counselors, and psychiatrists. If the therapist or doctor you are working with is not knowledgeable in this area and is not interested in learning about dissociation, you may want to find a new therapist or doctor.

Names of professionals who work in the area of dissociation can be found in the membership list of the International Society for the Study of Trauma and Dissociation (ISSTD). Please note that the ISSTD is a professional association and not a regulatory body. Therefore, a professional's membership does not guarantee competency, but it does demonstrate an interest in the field of trauma and dissociation. Here are some questions you may want to ask:

- What does the professional understand dissociation to mean?
    - Remember, not all children who dissociate have a dissociative disorder.
    - Dissociation is a blocking out of emotions, physical sensations, behaviors, or knowledge in order to feel safer when frightening things happen. It is like hiding somewhere in your mind where it feels safe while surviving on the outside in a dangerous situation.
- How does one recognize dissociation in a child?
    - Remember the types of shifts in behavior, emotions, thinking, and body sensations we talked about in FAQ 3
- What does a child with dissociation need to get better?
    - Remember the discussion in FAQ 7
- How will the therapist include you in the therapy?
    - Below is a list of ways a therapist may work with parents
- What type of training has the professional had in dissociation?
    - Training can come from reading, professional workshops and conferences, study groups, as well as university courses and ISSTD trauma and dissociation courses.

A careful and thorough assessment and, if recommended, therapy for your child will be important. The therapist should help you to:

- Understand dissociation, recognize when it is happening, and learn how to talk with your child at those times.
- Develop a greater sense of safety in the home.
- Identify the triggers that start your child's dissociative responses and how to decrease these triggers. A trigger is something in the child's present experience that is similar in some way to the situation at the time of the trauma (for example, cigarette smoke if the abuse smoked or smelling alcohol if the abuser used alcohol). Triggers restart the child's fear and the child is likely to respond to them just as she did when the actual trauma happened.
- Become aware of the various aspects or parts of your child.
- Establish a word or gesture that can help you reorient your child when dissociation starts to happen.
- Learn specific child-management techniques that can help your child assume responsibility for all of his behaviors and encourage a single sense of self.

The therapist will also work with your child individually to understand and decrease dissociative responding, process past traumas, and encourage integration of experiences and sense of self.

You may find that your child's behavior brings out strong negative responses in you and reminds you of bad experiences you had in the past. If this happens, it is smart to get some therapy for yourself. It is best to see a different therapist that the person who is treating your child. But again, it should be someone who is knowledgeable about dissociation. It may be helpful to have respite care so you have some time for yourself. Both you and your child may get along better if you have some time apart.

As you do things with your child, always refer to your child as a whole.

Acknowledge your child's different feelings and thoughts no matter how extreme they may seem to you. You might ask your child where those different feelings and thoughts come from and then talk with your child about appropriate ways to express those feelings. You might also ask what brought out (triggered) his reaction and how you can help him feel safer.

Your most important role as a parent is to be loving, understanding, and consistent in responding to your child (even though his reactions and behavior do not make sense to you). At the same time, there always need to be appropriate guidelines and consequences for his negative behaviors.

Safety for your child is of absolute importance! You will want to check each environment in which your child spends time (e.g., home, school, daycare, and scouts) to see if anything is unsafe or feels unsafe. Remind your child that is your job, not his, to fix things that do not feel safe. Always listen and appreciate your child when he talks to you about his world.

The journey towards understanding your child or adolescent is bound to be challenging and rewarding. Good luck!

These are several books and articles that you may find helpful:

- The Dissociative Child: Diagnosis, Treatment and Management edited by Joyanna Silberg (Sidran Press, 1998) contains several chapter of interest to parents. This is available as an electronic book from Sidra Press.
- Dissociative Children: Bridging the Inner and Outer Worlds by Lynda Shirar (Norton, 1996) is written for therapists but has several chapters at the beginning which would be helpful for parents.
- Techniques and Issues in Abuse-Focused Therapy with Children & Adolescents: Addressing the Internal Trauma by Sandra Wieland (Sage, 1998) has a chapter that would be helpful for parents.
- Stolbach, B.C. (2005). Psychotherapy of a dissociative 8-year-old boy burned at age 3. *Psychiatric Annals*. 35 (8), pp 685-694.
- Attaching in Adoption: Practical Tools for Today's Parents by Deborah Gray (Perspectives Press, 2002) has several references to dissociation and many ideas for parenting scared children.
- Two DVDs that are technical but could be helpful are Identifying and Responding to Childhood Trauma in Ages 0-5 years Old and Identifying and Responding to Childhood Trauma in Ages 6 to Adolescence by Bruce Perry. Magna Systems, Inc. 2002
- Two DVD sets that are more practical for parents (and teachers) are: Understanding the Traumatized Child, Parenting the Traumatized Child and Teaching the Traumatized Child. (Cavalcade Productions, 2004)