

Dissociative Experiences in Children with Complex Trauma

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Misdiagnosis

“Children with dissociative disorders are frequently misdiagnosed because of their comorbid symptomatology: attention deficit and hyperactivity disorder, conversion and other somatoform disorders, conduct disorder, oppositional defiant disorder, schizophrenia, various forms of epilepsy, and affective disorders (Zoroğlu et al., 1996)”.

+ Silberg & Dallam (2004)₂

Non-recognition

‘Kluft (1985) described reasons for the non-recognition of dissociative conditions by child clinicians. These reasons include lack of familiarity with dissociative phenomena, differences in the presentation of dissociation in children as compared to adults, the availability of more familiar diagnoses (e.g., ADHD, psychosis, seizure disorders), and the normative nature of fluctuating behaviors in children.

“In particular, the normative dissociative experiences of children can make it hard to differentiate between a **pathological process and imaginative involvement in play** (Haugaard, 2004). Finally, lacking a point of comparison, children and adolescents may not report dissociative symptoms; they may consider them to be normal”.

+ Silberg & Dallam (2004)

Putnam (1997)– Case of Penni

- + 6 years: IQ – 105 (significant scatter). Referred due to talking about ‘people inside her’ after being taken in foster care. List of imaginary friends, sexualised behavior and at times trance-like behaviors.
- + RECOMMENDATION: ‘To observe her and document evidence of dissociation and possible alter personalities, but not to aggressively seek out alters.’
- + Also noted: ‘I optimistically discussed how dissociative behavior may decline or disappear in many maltreated children when they are placed in a truly safe and stable living situation’ . (p221)

- + 6.5 years: Weekly psychotherapy. “Reports inside friends and frequent nightmares’ .
- + RECOMMENDATION: Individual and group therapy, Methylphenidate (15 mg 2xp/d; Diphenhydramine 25 mg to control nighttime agitation).
- + 7 years: Amnesia and variable performance, marked changes in handwriting.
- + Continued with medication

- + 9 years: Legally adopted by foster family. Behaviour has markedly worsened. ‘Spacey-like behaviours in which she seemed out of touch with reality and has a number of motor automatisms’ (fetal rocking and genital gyrations against objects).
- + 9.5 years: Serious problems with hyperactivity, attention, agitation, aggression, anger and nightmares, talking about running away and killing herself, highly sexualised and amnesia.
- + IQ – 107 “considerable scatter”
- + RECOMMENDATIONS: 15 mg Methylphenidate 3xp/d.

- + 10 years: Out of control behaviour, aggression and sexual touching at home and school.
- + ? Emerging thought disorder.
- + Hospitalized for 2 weeks.
- + Diagnosed as MPD.
- + Age 11: IQ – 94 ‘considerable variance between subtest scores’ .
- + RECOMMENDATION: Haloperidol 2mg 2xp/d, Clonaxepam, 5mg 3xpd; Methylphenidate and Benztropine

- + 12 years: **Exacerbation in behaviour – sexual acting** out at school.
(aggression and sexualised behaviour)
- + Started puberty at 9 years of age.
- + Was having therapy 2 times per week.
- + RECOMMENDATIONS: Methylphenidate, Clonazepam and Sertraline
- + **Therapist started to work directly with the dissociative states and the child started to become co-conscious.**

Putnam - conclusion

- + ‘Despite initial attempts to ignore and not reinforce her alter personality states, these and other pathological dissociative symptoms persisted and came to play a major role in her psychological and behavioural problems.
- + The case of Penni illustrates the consistency and chronicity of established alter personality states in some children’
 - + Putnam (1997;219 -226)

Signs of dissociation in children and adolescents

- + Hearing voices
- + Imaginary friends or 'people inside my head' (can also be experienced as external)
- + Lying (even in the face of witnesses)
- + Rapid 'switching' from one 'personality' to the next.

Signs of dissociation in children and adolescents

- + 'Shutting down', not being aware of the external environment.
- + Lose contact with reality
- + Amnesia (at times major problems with memory recall)
- + Inconsistent performance
- + Thought problems

Affect Avoidance Theory

“The affect avoidance framework views dissociative phenomenon from a **normalizing and adaptive perspective**. That is, this model is attentive to the ways in which the child’s **deviations in consciousness, identity development, affect or behaviour** have served to protect the child, and this model provides a **framework for redirecting the child incrementally back to behaviors** seen in a more normative developmental trajectory”

Silberg, 2013

Affect Avoidance Theory

“Affect Avoidance Theory defines dissociation as: **The automatic activation of patterns of actions, thought, perception, identity or relating (or affect scripts), which are overlearned and serve as conditioned avoidance responses to affective arousal associated with traumatic cues”**

Silberg, 2013

Pathological dissociation

“Pathological dissociation comprises some degree of a “structural division” within the self, causing disturbances in consciousness, memory, perception and/or identity”

(Waters, 2016)

What do the children say?

- + If you do not ask children directly whether they hear voices, they usually do not provide this information.
- + Most children, who are hearing voices, believe that hearing voices is normal and it happens to everybody.
- + Once children are about 10/11 years old they somehow find out it does not happen to all children.
- + Use questionnaires (C-Des, A-Des and CDC)

Inside-outside head (Baita, 2015)

Normal Uses of Imaginary Companions

- Embodiment of wished for traits
- Handling temporary conflict about unacceptable impulses
- Internalization of harsh expectations
- Help with loneliness

“Dissociation presents in traumatized children with dazed states, confusion in identity, voices or imaginary friends that influence behavior, mood, cognitions, somatic experiences, and relationships”

Silberg, 2013

Dr. Silberg conducted a study to determine whether hospitalized children with voices, imaginary friends, or alter identities were like normal children with imaginary friends.

She created a questionnaire to ask children about their imaginary friends, voices, and compared hospitalized children with children in a regular preschool.

Imaginary Friends in Normal Preschoolers Compared to Dissociative Inpatients

Questions about Imaginary Friends (IF)	Normal Children N=51 % responding yes	Dissociative Inpatients N=19 % responding yes	Confidence Level
IF comes whenever you want	76.%	47%	P < .02
IF comes when you are happy	94%	58%	P < .00
IF knows a lot of things you don't	82%	58%	P < .05
IF is only a pretend friend	78%	37%	P < .00
IF takes over and makes you do things	37%	74%	P < .01
IF tries to boss you	27%	72%	P < .00
IF does bad things and blames you	41%	74%	P < .05
IF tells to keep secrets	84%	41%	P < .00
IFs argue about you	25%	93%	P < .00
IFs come when you are angry	41%	79%	P < .00

Maladaptive fantasy in traumatized children

- Lack of control
- Sense of conflict
- Can't differentiate between real and imagined

Most significant findings. . .

- + The hospitalized children heard their “imaginary friends” when angry, not happy.
- + They felt little control.
- + They did not like having them.
- + They felt conflicted.
- + They were confused about whether they were real or imaginary.

Dr. Silberg's experience is that most children who present with voices, or imaginary friends that they perceive to be out of their control are not psychotic, but respond well to a trauma-based approach with focus on dissociation. (Silberg, 2013)

Case Discussion

Structural Dissociation

Van der Hart, Nijenhuis & Steele (2007)

PERSONALITY

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graph TD; A[PERSONALITY] --- B[APPARENTLY NORMAL PERSONALITY]; A --- C[EMOTIONAL PERSONALITY];
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APPARENTLY NORMAL
PERSONALITY

(Appears normal in certain
circumstances and with
certain people)

EMOTIONAL
PERSONALITY

(The part of the personality
that is holding the
emotional pain of the
trauma)

Treatment process (case discussed)

- + Attachment based therapy plus emotional regulation activities.
- + Stabilisation and internalise safety and trust in the parents.
- + Direct work with the dissociative states and processed trauma that caused the dissociative states. (EMDR/BLS plus sensory-motor activities and creative therapies)
- + Fully integrated

“.....children with complex trauma can have multiple domains of impairment, leading clinicians to base their diagnoses on the most florid symptoms, for example, inattention (ADHD), volatile mood swings, (bipolar disorder, attachment disturbances (reactive attachment disorder) (RAD), hallucinations, (psychosis), and many others, instead of seeing the compilation of symptoms and their relationship to a dissociative disorder” (Waters, 2016)

Conclusions

- + Screen all children for trauma and dissociation before providing any specific diagnoses.
- + Incorporate epigenetic background, pre-birth experiences, birth experiences, peri-natal experiences, any abuse, neglect, exposure to domestic violence, bullying, medical trauma etc. in the assessment process
- + Assess the attachments and capacity for emotional regulation during initial assessment.
- + **Do not Dissociate the Dissociation!**

References:

- + Baita, S. (2015a). Dalma (4-6 years old). "I've Got All My Sisters With Me". Treatment of Dissociative Identity Disorder in a Sexually Abused Young Child. In S. Wieland (Ed.), *Dissociation in Traumatized Children and Adolescents – Theory and Clinical Interventions* (2nd ed.) (pp. 41-88). London: Routledge.
- + Putnam, F.W. (1997). *Dissociation in children and adolescents*. New York: Guilford Press.
- + Silberg, J. & Dallam, S. (2009). *Dissociation in Children & Adolescents*. In: P. Dell & J. O'Neil (Eds), *Dissociation and Dissociative Disorders: DSM-V and beyond*. (pp. 67 - 81). New York: Routledge
- + Silberg, J. (2013). *The Child Survivor: Healing Developmental Trauma and Dissociation*. New York: Routledge
- + Waters, F.S. (2016) *Healing the Fractured Child: Diagnoses and Treatment of Youth with Dissociation*. New York: Springer Publishing Company.