



European Society for Trauma & Dissociation, UK Network

Dissociative Disorders in Children and Adolescents **Information for clinicians, social workers, parents,** **adopters, foster carers and NHS fund holders**

Introduction

Although studies of dissociation date back more than a century, it has not commonly been included in medical and other professional training in the UK. As a result, the concept of dissociative disorders in children and adolescents is still an unfamiliar concept. Yet, in practice there is an increasing amount of children and adolescents who are struggling with severe dissociation, who attract multiple diagnoses and have a history of many different types of therapeutic input. Without accurate assessment and diagnosis their difficult behaviour continues and usually steadily worsens over a period of time.

In children's services, awareness is growing and funding applications for assessment and treatment are becoming more common. This information is provided for clinicians such as general practitioners, psychiatrists, psychologists and psychotherapists and for fund holders to assist in assessing patients and in deciding funding applications for assessment and/or treatment. The information will also be beneficial for social workers, parents, adopters and foster carers who are often struggling with the behaviour of dissociative children over long periods of time.

Definition of dissociation

- **A disruption in the usually integrative functions of consciousness, memory, identity, or perception (DSM-IV).**
- For children and adults who are abused, neglected, or terrorized in some way, dissociation becomes a protective mechanism and may be repeated over and over again. Although protective, this distortion of perception and cognitive integration causes the child to lose touch with a part of her feelings, with part of her experience of self (Wieland, 2011).

Symptom profile

There is presently no specific diagnosis in the DSM IV classification for dissociative disorders in children and adolescents, just as there is no specific diagnosis for childhood trauma. However, many children referred to statutory and voluntary services are known to have suffered significant trauma for instance through abuse, domestic violence, medical procedures, bullying and neglect. Multiple differential diagnoses of ADHD, Developmental Attachment Disorder, Conduct Disorder, Obsessive Compulsive Disorder and Autistic Spectrum Disorder may be a feature because of the dissociative defences that the child or adolescent has used to survive adverse experiences.

Common problems in children with dissociation are:

- Lying/denial or minimising of serious incidents even when eyewitnesses are available to prove the contrary.
- Doing something and then unable to remember this.
- Shut down, excessive 'daydreaming'.
- Inconsistent performance, for instance the child is able to do maths one day and the next the child is not able to do maths.
- Hearing voices. (children only acknowledge this if they are directly asked).
- Special friends in their head that nobody knows about.
- Pre-occupation with fantasy figures even in an environment where it would be expected that the child would be able to remain in reality.
- Rapid and unprovoked changes from calm to aggressive or displaying infantile behaviour
- Noticeable changes in handwriting, preferences for food and clothes.
- Staring, glazed eyes or backward rolling of the eyes.
- In appropriate display of emotions.
- No memory of significant events.

Screening Tools

- Screening for dissociation should be considered whenever there is a history of severe or complex trauma. Any suitably qualified professional can use screening tools. The Child Dissociative Checklist (see below) can be completed by carers.
- The Adolescent Dissociative Experience Scale (A-Des) is the most important screening tool for adolescents. It is a self-report questionnaire where the adolescent can identify and score his/her subjective experiences of dissociation.
- The Child Dissociative Checklist (CDC) is a questionnaire that the parents, carers or teachers of the child or adolescent can complete in order to score their experiences of the child or young person's dissociative experiences. It has been found to have excellent validity and reliability.

- The Children's Dissociative Experiences Scale and Posttraumatic Symptom Inventory (C-Des) has been designed to assess Trauma Symptoms and Dissociation in a population of children aged 7 – 12 years. There are two versions, the one is for boys and the other one is for girls. It is a child friendly self-report questionnaire where the child can provide scores on the subjective experiences of trauma symptoms and dissociation. There are two practice items as well as three fake scores indicating the accuracy of the responses.

Copies of the The Child Dissociative Checklist and the Adolescent Dissociative Experience Scale can be downloaded free of charge from the ESTD website (www.estd.org). All the tools are provided for participants undertaking the ISSTD training module (details below)

Assessment

Clinical assessment of the child or adolescent is the most important part of identifying dissociation. According to the international Guidelines for the Evaluation and Treatment of Dissociative Symptoms Children and Adolescents :

Children and adolescents may present with a variety of dissociative symptoms that reflect a lack of coherence in the self-assembly of mental functioning:

1. *Inconsistent consciousness may be reflected in symptoms of fluctuating attention, such as trance states or “black outs.”*
2. *Autobiographical forgetfulness and fluctuations in access to knowledge may reflect incoherence in developmental memory processes.*
3. *Fluctuating moods and behavior, including rage episodes and regressions, may reflect difficulties in self-regulation.*
4. *The child's belief in alternate selves or imaginary friends that control the child's behavior may reflect disorganization in the development of a cohesive self.*
5. *Depersonalization and derealization may reflect a subjective sense of dissociation from normal body sensation and perception or from a sense of self (<http://www.isst-d.org/education/dissociation-101.htm>)*

During clinical assessment, dissociative signs can often be observed in art work such as drawings where there is fragmentation in people's bodies, multiple people all representing the self of the child and multiple mouths, eyes or dots all over the body. When directly asked the children often report voices in their head, 'special friends' or 'people' inside their head. Different from the normal imaginary friends that we often get with young children, children with dissociation often report that these 'special friends' or 'inside people' are often 'fighting', 'shouting' or 'making noises' which the child can find very distracting.

Children can also 'shut down', totally withdraw or present very different from one moment to the next. The well groomed child or adolescent that walked into the assessment may quickly change, using a toddler voice or becoming extremely demanding and controlling.

Parents and teachers often report excessive 'spacing out', 'daydreaming' and inconsistent performance. They also often noticed rapid changes of emotional states and incessant lying, even when there was a witness who has observed them doing something wrong.

Diagnosis

There is presently no official diagnosis in the DSM-IV classification on dissociative disorders in children. Silberg (1996:7-9) extensively described the fruitless struggle of her and her colleagues to get childhood dissociation included in the DSM-IV. While some clinicians are still debating the formal existence of dissociation in children, many children are suffering increasingly with multiple diagnoses, and a series of failed interventions. These children and adolescents often display increasing problems in terms of aggression, self-harming, sexualized behaviour, 'pathological lying', inability to regulate their emotions and inability to develop age appropriate attachments and social relationships. On the other hand there are books, articles and training that provide a theoretical framework and guidelines for effective assessment and treatment of children with severe dissociation. (See Clinical and Research literature below).

According to the ISSTD Guidelines for the Evaluation and Treatment of Dissociative Symptoms Children and Adolescents, dissociation is seen in populations of children and adolescents with other disorders such as Post-Traumatic Stress Disorder, Obsessive- Compulsive Disorder, and Reactive Attachment Disorder, as well as in general populations of traumatized and hospitalized adolescents and delinquent adolescents.

The Guidelines state that: *'Although even very young children appearing to meet the criteria for DID have been described --- the prevalence of DID in childhood is currently unknown. The diagnosis of Dissociative Disorder Not Otherwise Specified (DDNOS) is the most common in populations of dissociative children and adolescents (Putnam et al., 1996), even though no diagnostic criteria have been set for this diagnosis. While individual case studies of children with puzzling and atypical dissociative presentations --- continue to be published in peer-reviewed journals, there is still no real consensus about the typical case and thus no consensus about diagnostic criteria. For this reason, in these Guidelines the perspective on assessment and treatment is symptom-based'*.

Treatment

The ISSTD Guidelines for the Evaluation and Treatment of Dissociative Symptoms Children and Adolescents state that '*Treatment strategies aimed at increasing integration and reducing dissociation can be highly effective in treating some of the most seriously impaired child victims of maltreatment who are engaged in disruptive and self-destructive behavior*'

The treatment of the child with dissociative symptoms always has to involve the family, carers and teachers of the child, provided the child is protected from on-going or further trauma. It is imperative for the child to feel safe and experience empathy and understanding from the people caring for him/her, while also putting effective boundaries in place.

Therapeutic Goals

1. Help the child achieve a sense of cohesiveness about his affects, cognitions, and associated behavior.
2. Enhance motivation for growth and future
3. Promote self-acceptance of behavior and self-knowledge about feelings viewed as unacceptable.
4. Help the child resolve conflicting feelings, wishes, loyalties, identifications, or contrasting expectations.
5. Desensitize traumatic memories, and correct learned attitudes towards life resulting from traumatic events.
6. Promote autonomy and encourage the child to independently regulate and express affects and to self-regulate state changes.
7. Promote healthy attachments and relationships through direct expression of feelings.

Prognosis

If dissociation in children can be identified early, it is relatively easy to treat and can prevent the development of more severe dissociation and mental health problems in adolescence and adulthood. Wieland (2011) gives numerous case studies from clinicians across the world who have effectively treated children, following the international Guidelines referred to above and below.

Relevant guidelines

NICE has not yet produced any guidelines for the dissociative conditions in children. The only available guidelines are provided by the International Society for the Study and Treatment of Dissociation (ISSTD). See www.isst-d.org for a free downloadable copy of the Guidelines for the Evaluation and Treatment of Children and Adolescents, published in the Journal of Trauma & Dissociation, Vol. 5(3) 2004. These will also be published on the ESTD website shortly (www.estd.org).

The information in the ISSTD Guidelines may be new to funding committees in the NHS and elsewhere.

The ISSTD Guidelines meet the standards normally expected by NICE. They summarize expert consensus concerning effective assessment and treatment for patients suffering from dissociation and present key findings and generally accepted principles that reflect current scientific knowledge and clinical experience specific to the diagnosis and treatment of dissociative disorders.

Dissociative disorders in adults

A separate information sheet re the dissociative conditions in adults has been prepared by ETSD UK, available via the ESTD website (www.estd.org). Separate screening and assessment tools and international guidelines are available for this age group.

Further information and resources

Training

A four-day training is available to all clinicians who want to be more effective in assessing and treating dissociation in children and adolescents. An accredited trainer for the ISSTD who lives and practices in England provides the training. Participants receive articles and literature on dissociation in children & learn through case discussions, videos and formal training. Further information regarding this training can be obtained at childdissociation@yahoo.co.uk.

Information for parents and teachers

- Further information for parents is available on <http://www.isst-d.org/education/faq-child.htm>
- Further information for teachers is available on <http://www.isst-d.org/education/faq-teachers.ht>

Professional bodies

- European Society for Trauma and Dissociation (www.estd.org)
- International Society for the Study of Trauma and Dissociation (www.isst.org)

Clinical and Research literature

- Liotti, G. (2009) Dissociation and attachment. In: Dell, PF & O'Neill, JA (Eds.) *Dissociation and Dissociative Disorders DSM –V and Beyond*. London: Brunner -Routledge.
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 - Wieland, S. 2011. *Dissociation in Children and Adolescents: Theory and Clinical Interventions*. London: Brunner -Routledge