HEALING THE FRACTURED CHILD

DIAGNOSIS AND TREATMENT OF YOUTH WITH DISSOCIATION

FRANCES S. WATERS
ADVANCE PRAISE FOR HEALING THE FRACTURED CHILD

Anyone who works with troubled children and their families should not miss this book. Healing the Fractured Child weaves together comprehensive theory and neurobiology that substantiate practical treatment guidelines for children and their families. The complexity of symptoms, diagnoses, assessment, and use of medication and a variety of innovative treatment approaches for stabilization, trauma processing, and integration are explored and come to life through the clear, practical, and touching clinical illustrations peppered throughout the book. Fran Waters has drawn on her vast clinical experience and thorough knowledge of current perspectives on dissociation and child therapy to write an integrative, readable, and immensely useful masterpiece, a gift to the field of child psychology and psychotherapy and to the many therapists, children, and parents who will benefit from her wisdom.

—Pat Ogden, PhD, Founder, Sensorimotor Psychotherapy Institute

Healing the Fractured Child provides an invaluable source of information for all professionals and nonprofessionals interested in childhood dissociation. Based on her many years of experience in this field, Waters takes us from an explanation of dissociation and related theories to the behaviors that may be noticed by a parent, teacher, or doctor, through the assessment quagmire and the challenges of parenting, to the important work of emotional regulation and the identification of self-states, bringing in consideration of where medication can or cannot assist and describing the hard work of trauma processing, to integration, possible relapse, and back again to even stronger internal integration. The intricately described clinical examples provide a plethora of ideas for working with these children and offer readers the encouragement and hope so important for working with children who experienced trauma.

—Sandra Wieland, PhD, RPsych, Editor of Dissociation in Traumatized Children and Adolescents, Second Edition: Theory and Clinical Interventions

Healing the Fractured Child is a skillfully written, comprehensive, and remarkable volume. It is well grounded in theory and full of rich, practical applications and detailed case examples. Waters’s outstanding work will expand clinicians’ capacity to understand and assess dissociation as well as to effectively accompany children in their healing journeys. It is an essential resource for therapists of all orientations working with trauma and dissociation.

—Ana M. Gómez, MC, LPC, Author of EMDR Therapy and Adjunct Approaches With Children: Complex Trauma, Attachment, and Dissociation

This book is a compilation of years’ worth of clinical work with traumatized, dissociatively fractured children, and the author’s sensitivity and accumulated wisdom are on every page. With her integrative model, Fran Waters makes the behaviors of these traumatized children—which are seemingly incomprehensible and often misdiagnosed—understandable and even logical. Therapists, parents, and others who are in a position to interact with the dissociative child can benefit from this book with its down-to-earth and practical explanations and intervention strategies. It belongs in the library of all who treat these children and those who treat adult survivors of childhood abuse. Brava!

—Christine A. Courtois, PhD, ABPP, Licensed Psychologist, Independent Practice, Washington, DC
Frances S. Waters, DCSW, LMSW, LMFT, a clinical social worker and a licensed marriage and family therapist in private practice in Marquette, Michigan, is an internationally recognized educator, trainer, consultant, and clinician in the areas of childhood trauma, abuse, and dissociation.

She was the past president of the International Society for the Study of Trauma and Dissociation (ISSTD), and she is currently the faculty director of the Child and Adolescent Psychotherapy Training Institute and the cochair of the ISSTD’s Child and Adolescent Committee. She has authored numerous articles and chapters and serves on the editorial board of the Journal of Child and Adolescent Trauma, as well as on the advisory board of the Leadership Council on Child Abuse and Interpersonal Violence.

Fran Waters is an executive producer and a participant of several training videos on childhood trauma, abuse, and dissociation targeted toward mental health professionals, caretakers, teachers, child protective services workers, forensic evaluators, and prosecutors. She received the 2008 Media Award from the American Professional Society on Abuse of Children for her production of “Trauma and Dissociation in Children,” which was geared toward forensic evaluators and prosecutors. She is the recipient of ISSTD’s Presidential Award and is a fellow of the ISSTD.
HEALING THE FRACTURED CHILD

DIAGNOSIS AND TREATMENT OF YOUTH WITH DISSOCIATION

Frances S. Waters, DCSW, LMSW, LMFT
This book is dedicated to all the children and families who trusted me to work with them and to share their stories. I have learned from them and been inspired by their strength.
CONTENTS

Contributors ix
Foreword by Joyanna Silberg xi
Preface xvii
Acknowledgments xix
Introduction xxiii

I THEORY 1

1 The Star Theoretical Model: An Integrative Model for Assessing and Treating Childhood Dissociation 3

II ASSESSMENT 45

2 What’s Going On With This Child? Recognizing Warning Signs of Dissociation in Traumatized Children and Adolescents 47

3 Deciphering What Is Dissociation: Differential Diagnoses 69

4 Uncovering the Child’s Fractured Self: Assessing for Dissociation 97

III TREATMENT 131

5 Mindful Approach to Phase-Oriented Treatment 133

6 “I Guess They’re Going to Keep Me. I Tried Everything . . .”: Building Attachment and Partnering With the Family 149

7 “My Invisible Team”: Identifying and Stabilizing Self-States 179

8 Calming the Stress-Response System and Managing Triggers 219
Contents

9 Medication as an Intervention in the Treatment of Dissociative Disorders and Complex Trauma With Children and Adolescents 249
   With Adrian J. Stierum

10 Mastering Traumatic Memories 283

11 Hidden Voices: Creative Art Therapy Interventions for Adolescents With Dissociation 321
   With Diane Raven

12 Integrating Dissociative Treatment and EMDR Therapy With Children With Trauma and Dissociation 353

13 “It’s Like You’re in a New World”: Integrating the Fractured Child 385

Appendix A: Internet Resources and Additional Readings 417

Appendix B: Checklists for Children 421

Appendix C: Questions to Ask Children, Parents, and Therapists 433

Appendix D: Tools to Use 441

References 443

Index 473
Contributors

Diane Raven, BS, MA, Consultant and Former Clinical Therapist/Director of Art Therapy, Youth Residential Services, Great Lakes Recovery Centers, Behavioral Health Services, Negaunee, Michigan

Adrian J. Stierum, MD, Child and Adolescent Psychiatrist, Orthopsychiatric Center, De Fjord, Lucertis, Rotterdam, The Netherlands
In 1996, in an endorsement of the book *The Dissociative Child*, Joseph Noshpitz, one of the forefathers of present-day child psychiatry, wrote, “These authors have lit a candle in a dark cave” (solicited endorsement; Noshpitz, personal communication, 1996). Now with Frances S. Waters’s book *Healing the Fractured Child: Diagnosis and Treatment of Youth With Dissociation*, the lights in the cave may have finally been turned on. This book is a significant step forward in the developing field of dissociative disorders, adding a comprehensive treatment compendium to the five existing books on the topic: Shirar (1996), Silberg (1998), Putnam (1997), Wieland (2015b), and Silberg (2013). Waters’s contribution may very well move this marginalized field of dissociation in children into the mainstream of the field of child clinical psychopathology.

Waters desensitizes the reader to the oddness or bizarre quality of dissociated selves in children by reference to classic child developmental literature. It turns out that Bowlby (1980) clearly described children with dissociative reactions in his work, and these are the observable phenomena in the astute clinician’s office in 2016 as well.

Frances Waters allows us insight into her remarkable career by illustrating interventions with children whom many child practitioners would have given up on. Frances Waters’s treatment of the most aggressive, regressed, and impaired children uses the Star Theoretical Model (STM) to inform her work. She focuses on the theoretical contributions of Satir (1965), Bowlby (1980), and Erikson (1963), highlighted by recent neurobiological research and the growing field of dissociation studies.

Waters’s scholarly summary of the differential diagnosis issues between dissociative disorders in children and attention deficit hyperactivity disorder, pediatric bipolar disorder, psychotic disorders, obsessive-compulsive disorders, eating disorders, and reactive attachment disorder is the most comprehensive in the literature to date, and illustrates that
a trauma-informed perspective can radically alter our conventional approaches to a variety of childhood conditions.

It is moving to read Frances Waters’s detailed descriptions of trauma processing with dialogues between Waters and clients’ different self-states, which show the young people’s incredible insight, self-knowledge, and sensitivity. One is in awe of these young people who, despite their suffering, feel the motivation to heal and thrive under Waters’s sensitive therapeutic guidance. Reading these case histories makes it clear that the power and resiliency within children are powerful forces and that clinical skill in tapping into the well of resourcefulness in young people can yield amazing clinical rewards. Waters illustrates how to tap into that well of resiliency and healing through creative engagement with the child and teen ego states, which hold memories of trauma, but also may hold powerful protective resources and insight.

As Sobol and Schneider (1998, p. 192) stated, “An image developed and changed through art-making may alter or amend internal imagery.” Frances Waters, along with Diane Raven, presents a detailed map of how to use art interventions to encourage self-awareness and ultimate integration for traumatized and dissociative teens (Chapter 11). Art therapists and child therapists who have abundant art materials in their offices can use or adapt many of these techniques in their own offices. The combination of a variety of media in the same projects—masks and paintings, rocks and clay—helps the clients portray their own discontinuity of self and gives a concrete language for expressing internal fragmentation. It is clear how powerful these strategies can be, and I intend to incorporate some of them immediately in my own practice, as I expect many practitioners reading this book will do after becoming familiar with this clear description of art interventions.

For therapists who work with eye movement desensitization and reprocessing (EMDR), Waters provides a detailed methodology for the incorporation of sensitivity to dissociation within the EMDR model (Chapter 12). This will definitely be a useful addition to the literature in bridging these two clinical methodologies. Similarly, psychiatrists asked to augment treatment through medication will appreciate the in-depth discussion of psychiatric medications coauthored by Adrian J. Stierum (Chapter 9).

One of the most powerful points illustrated in Waters’s book is that one ignores the traumatic roots of childhood behavioral disorders at great peril. The urgency and importance of this lesson are illustrated in a recent clinical experience from my own practice. My client, 8-year-old Robert, was evaluated at a well-known treatment center in my city, and that clinical
evaluation was to be used with mine as part of the court’s determination of his treatment needs and the suitability of his placement with his maternal grandparents after his parents’ tragic death in a car accident. Robert displayed intermittent aggressive behavior that seemed unpredictable: He would attack his maternal grandparents, shouting “Watch out!” These aggressive episodes alternated with regressed behavior in which he spoke like a baby, curled in a ball and weeping. His paternal grandparents argued that this out-of-control behavior indicated that the home of the maternal grandparents was inappropriate to his needs. The report from the well-known treatment facility in my area emphasized that the maternal grandparents clearly needed parenting training in which they would be taught to reinforce his positive behavior and ignore his angry behavior. The obvious grief reaction of the child and the importance of the words “Watch out!” (which were the last words he heard his parents say before the crash) were ignored. The treatment philosophy of this center was to treat the observable behavior no matter what the child was experiencing internally.

In contrast, my report emphasized a trauma-focused approach, wherein Robert could safely play out his traumatic memories with support, encouragement, and validation. I argued his behavior did not reflect on the suitability of his placement. My approach, like that of Frances Waters, encouraged attention to his changing states and recognition that his aggressive state was a fear-based, state-dependent reaction that evoked its own set of state-dependent memories of the accident. To simply ignore these episodes would be a way to invalidate the central defining experience of Robert’s young and tragic life. The judge, unsure whom to believe, ordered the child to stay where he was and engage in both forms of treatment, but the maternal grandparents soon came to realize that the behavior modification approach was accomplishing little and often antagonized Robert when he most needed support and validation.

Yet, how many other times is a behavioral approach like this one ordered for children like Robert who have suffered tragedies of family members’ death; sexual, physical, or emotional abuse; witnessing community and domestic violence; or sudden separation from loved ones? How many clinicians who deal with children are taught to rely exclusively on simplistic treatment ideologies that are actually causing children more harm by ignoring the traumatic roots of their behavioral presentations? I wish I could answer that the trauma-informed movement in public mental health has saturated the delivery of mental health care to children, but we are not there yet.
Yet, paradoxically, when the posttraumatic nature of the symptom presentation becomes evident, there is often reluctance among treatment facilities or providers to accept the client. An article in the New York Daily News on November 19, 2015, reported on a 12-year-old girl with dissociative identity disorder diagnosed by three psychiatrists, who was refused entrance to 16 treatment facilities (Salinger, 2015). She languishes in a juvenile detention center in Indiana, while all the child and adolescent mental health services in the surrounding area feel ill equipped to handle her case.

However, the expertise to handle children and adolescents with dissociative disorder exists, and it is time for this previously marginalized field of expertise to reach the mainstream of psychiatric services. Based on consultation calls that I receive from treatment centers around the world, there is awareness that these dissociative clients require a specialized approach, that the expertise to handle them is rare, and that there is a growing need for centers that treat psychiatrically impaired teens to gain expertise in treating dissociative disorders in youth. Recent calls to me seeking consultation about this specialized treatment have come from Israel, Turkey, Hong Kong, the United Kingdom, Canada, and multiple states within the United States. When I explain some of the foundational concepts of treating dissociative disorders in these consultations, it is as if a lightbulb turns on. Practitioners recognize that the process of radical self-acceptance and the integration and processing of experienced pain and trauma, emphasized by practitioners who treat dissociation, are intuitive and logical. Growth-enhancing approaches such as those described by Waters in this book promote respect for the individual’s adaptive capacities without blaming, categorizing, and labeling and are powerful psychotherapeutic interventions. In a recent consultation, when I suggested that the therapist praise a traumatized teen for his ability to fight back, rather than just set limits on the teen’s aggressive behavior, the therapist smiled with delight and recognition. “Arthur will love that!” he recognized immediately, and laughed with relief that he could say out loud what he intuitively understood: This severely traumatized boy needed affirmation that moving out of helplessness into mastery was essential for self-preservation, and although his aggression was misdirected initially, the impulse to care for himself was a necessary survival tool that this young teen could acknowledge in himself with gratitude, while still working on learning to curb its intensity.

The world around us seems to be getting more violent all the time. The Internet provides a ready medium for those who wish to harm children to document and disseminate evidence of their crimes. Increasingly,
level of trauma our children experience boggles the imagination. Frances Waters models courage in the face of the most seemingly intractable symptoms and gives hope that even these children, exposed to the most horrific abuse or events, have the potential to heal with sensitive awareness of how they have coped with trauma. Waters’s book is essential reading for all clinicians who treat children. Let us all hope for a time when one of the primary pathways that children demonstrate in reaction to trauma—dissociation with its associated fragmentation and identity confusion—is recognized widely, and the emotional pain of the youngest members of our population is treated with the sensitivity and care shown by Frances Waters.

Joyanna Silberg, PhD
Senior Consultant, Childhood Trauma
Sheppard Pratt Health System
Baltimore, Maryland

REFERENCES


Preface

Healing the Fractured Child: Diagnosis and Treatment of Youth With Dissociation is a comprehensive book on child and adolescent dissociation that provides the reader with a window into the fractured minds of traumatized children and adolescents and offers an effective pathway toward healing. This book delves into the inner workings of vulnerable children’s use of dissociation—an adaptive defense when fighting or fleeing is simply not an option. An in-depth discussion of the Star Theoretical Model (STM), an inclusive theoretical model that examines five intersecting theories—attachment, neurobiology, developmental theory, family systems, and dissociation—provides a solid foundation for understanding how and why children dissociate and also a road map to guide traumatized children toward successful recovery. The attachment theory is given special attention in the STM, signifying the critical relationship between children and their healthy caregivers, as a strong attachment provides the anchor for children to dissolve dissociative defenses and for them to begin to process traumatic experiences.

Because dissociation can result in a confusing array of symptoms, these children are frequently misdiagnosed, resulting in years of failed treatment episodes, multiple placements, and despondent children and caregivers. Several chapters cover a thorough analysis of traumatized children’s convoluted behaviors by examining overlapping symptoms and differential diagnoses, dissociative warning signs, and a thorough assessment process for accurate diagnosis, all of which are dynamically illustrated with actual cases.

Throughout the book, rich clinical vignettes, telling drawings, and meaningful dialogue between therapist and child highlight the intricate therapeutic process from assessment to final integration. Innovative, varied, and specialized therapeutic techniques that are designed for each child’s unique inner world are described; these techniques engage all parts of the child in healing and integration. Clinical examples of dissociative
children from varied backgrounds and ages and with a high rate of comorbidity, such as destructive behaviors and substance abuse, are provided with specific interventions. Because infant trauma is often overlooked as the origin of children’s memory and behavioral and emotional disturbances, special attention is given to illustrating innovative, evidence-supported techniques to access hidden infant states that often encapsulate the child’s most disturbing and retractable symptoms.

The journey of four children’s healing—Rudy, Lisa, Cathy, and Briana—is followed throughout the book. Other clinical vignettes are described as well, illustrating techniques that are often simple, yet powerful, to perform and easily adapt to other dissociative children. Special emphasis is given to stabilization techniques that are tailored to the child’s interests; the use of these techniques is reinforced throughout the trauma processing stage for mastery of traumatic experiences and facilitates integration. Although adjunctive therapy with medication cannot cure dissociation in clients, special attention is devoted to carefully examining the judicious and safe use of medication for stabilization of highly dysregulated, dissociative children. A psychodynamic approach that is specially designed to treat traumatized children with dissociation and that combines other treatment modalities, particularly eye movement desensitization and reprocessing (EMDR) and art therapy, is given particular attention, with numerous case illustrations that demonstrate its success.

This invaluable resource provides mental health clinicians and other health care professionals with a wealth of knowledge and tools to effectively treat this troubled client population.
Acknowledgments

I am most grateful to my family for having supported me throughout this process. My husband, Bill, gave me his university library card so that I could have access to all of the materials needed to write this book, picked up materials for me at the library, and tolerated the time it took for me to complete this book. My son, Anthony, spent hours reviewing the chapter on differential diagnosis while using his doctoral degree in psychology to question, correct, or clarify what I wanted to say. I humorously told him it was “payback” time. My other son, Vincent, was always interested in my progress and firmly supported me throughout this process.

I am very thankful for Stephanie Dallam’s scholarly editing skills, commitment, and lots of hard work to make this book much better. Her efforts were invaluable. I thank my two contributing authors, Diane Raven and Adrian J. Stierum, for their contributions to this book. Diane shared her innovative art interventions, which will be a major contribution to the field in helping youth reveal their inner life and safely express through art what would have otherwise been difficult to do. Adrian’s thorough review of medications with dissociative children and case studies is an invaluable contribution to the field that has not been written about in almost 20 years! I am grateful to Robbie Adler-Tapia for her contributions to my chapter on EMDR (Chapter 12). She generously supplied cases and materials to keep me better informed about EMDR therapy. She also encouraged and guided me through the publication process.

I am deeply indebted to my colleagues and friends who are involved in child/adolescent treatment. Joy Silberg, Madge Bray, and I met in 1990 and have been kindred spirits, forging ahead in sharing knowledge and developing the field. Joy has been an invaluable and esteemed collaborator, as we have shared trainings and writings for the past 25 years! Her consultations and encouragement to write this book are immeasurable. I am better for what I do because of her innovations and contributions to the field. Madge Bray’s creativity always amazes me. I am most thankful
Acknowledgments

for her gift to me of her specially designed “dissociative doll” with little parts. It has become a prototype for all other similar dolls and has been an invaluable tool in my practice.

I had the honor to meet Renee Potgieter-Marks in the late 1990s; I have valued her creativity and insight, and I treasure our ongoing trainings and fun times together afterward! I am richer for her contributions and collaborations. I am also indebted to wonderful colleagues and cochairs of ISSTD’s Child Adolescent Committee, Sandra Wieland and Na’ama Yehuda. Their persistence and dedication helped to get committee tasks done, as well as ensured their participation as copresenters with me. Also, their writings have advanced the field. Other members of the Child Adolescent Committee, Sandra Baita, Brad Stolbach, Bengt Soderstrom, and Els Grimminck, have enriched my growth by fertilizing ideas, collaborating, and sharing in trainings. I appreciate other members of the committee, Robert Slater, Robert Muller, and Frances Dougherty, for their devotion to serve and participate in committee work.

I learned so much in my early days from esteemed colleagues. In the 1980s, Mary K. Peterson, infant mental health specialist, collaborated with me about infants and attachment, introducing me to the significance on their development of infants’ primary relationships to their parents; this has tremendously influenced my work and writings. Phyllis Stien, psychiatric nurse and dear friend who specialized in early childhood, family therapy, and neurobiology, patiently taught me about the neurobiology of trauma, brain structures, and their functions, which provided me the foundation to better understand the intricacies of the brain and to write about this topic. We also had lots of fun presenting together. I am grateful for the support of other local colleagues, Hannah Steintz and Kelly Laasko.

I particularly am most grateful to the late Roger McKinley and late Ann Bailey, who were my mentors. When I was faced with my first case of childhood dissociative identity disorder (DID) in the mid-1980s, I was fortunate to connect with them, who unselfishly gave endless hours of their time to collaborate with me and to participate as cotherapists with initial cases of dissociative children I treated. They taught me about dissociation, and we became a team in those early days. Also, I learned so much from Rick Kluft in those early days, and I continue to do so from his trainings and writings. His deep understanding of the fractured mind and how to engage the client with various techniques are what I have adapted to children. Frank Putnam’s writings, theories, and trainings have added to my understanding and are the basis of my work with children. The
dedicated work and writings of Christine Courtois have added depth to my understanding of trauma and dissociation. Ralf and Irina Votz, Pat Ogden, Janine Fisher, Bessel van der Kolk, Peter Levine, and Robert Scaer have enhanced my understanding of how the body holds the trauma and is the portal toward recovery. I have adapted their techniques to children and hundreds of children have benefited. Kathy Steele, Ellert Nijenhuis, and Onna van der Hart’s theory on structural dissociation and research have added to my deep understanding of how the mind can divide to survive. Steve Frankel, Phil Kinsler, Phil Kaplan, and Bob Geffner have enriched my understanding of forensic evaluations that I have applied to my assessments of dissociative children. I am particularly indebted to Steve Frankel for his time in collaborating and guiding me on many cases of traumatized, dissociative children. Bob Geffner’s endless drive, energy, and devotion to educate clinicians about trauma and dissociation always amaze me. Kevin Connor’s spirit and drive in the early days and currently to move the field forward in education and training have been an inspiration to me over the past 30 years and provided me with opportunities to conduct trainings.

I am also grateful to ISSTD’s leadership—past presidents and board members—who have guided me in this field throughout the years.

Regarding technical support, I appreciate Northern Michigan University’s research librarian, Mike Strahan, for giving me many hours to learn a reference program for my book, and to obtain numerous articles and books. I am also most appreciative of Michael Weinhold’s ongoing support and advice in technology, and assistance in preparing all of the figures for this book.

My dear friends, Rosanne Cook, Ann Russ, and Diana Magnuson, have been great supporters of me during this process, listening to my excitement, frustrations, and challenges. They kept me going.

Although my life’s work has been influenced by many more—too numerous to mention—I appreciate all that they have done to contribute to my growth!
In the early 1980s, I developed a successful treatment protocol for sexually abused children, and then I ran into a roadblock in treating a child. In 1986, after 1½ years of working with severely traumatized 8-year-old Eliza (name has been changed to protect her identity), she simply was not making progress. I was dumbfounded. Fortuitously, the psychiatrist, Dr. Lu Kuhnhoff, at the local mental health center where I worked at the time had attended one of the early international conferences sponsored by the International Society for the Study of Multiple Personality and Dissociation, now called the International Society for the Study of Trauma and Dissociation (ISSTD). On her return to the clinic, Dr. Kuhnhoff provided a 2-hour in-service on indicators and symptoms of dissociation. I attended it, along with a small group of clinicians. I was intrigued by this strange phenomenon and thought that perhaps I would see one in my lifetime. Little did I know what would transpire with my caseload and where I would be almost 30 years later!

Back to Eliza. . . . One day, Eliza walked into my office as if it were her first time. She looked at my bookshelf and toys, inquiring what they were. This was not the Eliza I had known. And it was thus truly her first time in my office! I then began to ask whether she heard voices, and she responded that she did. I took a deep breath and wondered where to go from there. I then inquired about her name, and she told me that her name was Samantha. I was a bit stunned and was not sure how to proceed, but since she liked to draw, I asked her to draw a picture of her voice and tell me about it.

I began to recognize that Eliza’s dissociation was not a rare condition among other traumatized children whom I treated. I developed a treatment protocol for treating dissociative children and adolescents that not only included their traumatic experiences but also included “all parts of them.” I pursued ongoing consultation and education by attending yearly the ISSTD’s international conference and have not missed a conference since 1988.
Introduction

Since those early days until the present, I have found it disheartening to see severely traumatized children and adolescents suffer with years of unsuccessful treatment, multiple diagnoses, and failed placements. When they finally come my way, many are well into their adulthood. Although I have written in the field and trained internationally, I decided it was time (a bit overdue) to write a comprehensive book on assessing and treating dissociative children. My hope is that this book will encourage clinicians (and researchers) to examine dissociation as a central feature in a long list of comorbid symptoms that children with complex trauma demonstrate.

Throughout this book, I emphasize that all treatment interventions should be geared toward unity of the fractured child. I stress the importance of developing internal awareness, cooperation, and participation across all parts of the self (referred to primarily as self-states in my book and also referred to as ego states, alters, parts, or introjects) in resolving traumatic experiences. I emphasize the importance of attachment and the family in the healing of the child’s fractured mind. Rich clinical examples are described throughout the book with some cases, such as Rudy, Lisa, Cathy, and Briana, being followed in each phase of treatment. These case examples and many more in the book provide a window into the internal world of dissociative children and a pathway toward healing.

In Chapter 1, I focus on the Star Theoretical Model (STM), a comprehensive model of five theories—attachment, neurobiology, developmental theory, family systems, and dissociation—that in combination explain the development and treatment of dissociation in children and adolescents. At the top of the star shape is attachment, which is given paramount importance, as the attachment style of the child to parents/caregivers can either contribute to the child’s reliance on dissociation or provide the foundation to help the child release dissociative defenses. I draw heavily on Bowlby (1980), the father of attachment theory, and his description of children who display dissociative symptoms when separated from their mothers. I describe a comparison between Bowlby’s psychosocial stages of loss and mourning (1960) and children who also endure other traumatic experiences, and how these children react similarly by further segmenting off these painful affects, thoughts, and behaviors into self-states.

In the STM, I also draw wisdom from other prominent researchers (e.g., Schore, 2009) who examine the connection between frightening and abusive parents and the development of dissociation in youth. Discussion on the dynamics of attachment relationships between the child and maltreating caregiver, and the science of mirror neurons between a child and
significant others, can shed light on the development of a child’s self-states that mirror abusers, nonabusers, and so forth.

In the STM, the neurobiology of trauma is a central theory to understanding dissociation. I discuss Porges’s (2011) triune autonomic stress response system, which explains the most primitive, automatic defense system—freeze, immobilization, dissociation—when a child is exposed to trauma and cannot utilize other defenses of fight or flight. The impact of trauma on the child’s developing brain and the impairment of critical memory systems that shed light on memory disturbances are reviewed, including groundbreaking research on how traumatic memories are stored differently, thus making them inaccessible (Jovasevic et al., 2015).

Numerous theories on dissociation and development of discrete states and how they overlap with attachment (e.g., Putnam, 1997) are highlighted and influence my work. Erikson’s (1963) psychosocial stages of development are the basis of my developmental theory. I expand Erikson’s model by incorporating into my developmental model the theories of dissociation and how trauma impacts a child’s developmental stage, particularly at the time of the trauma, resulting in self-states that are stuck at that developmental stage. Finally, Satir’s (1965) theory of family systems is the basis of my approach to families. Her principles and strategies are timeless and recognize that the identified client, the child, is often reacting to a dysfunctional family. She stresses the importance of examining the interactional patterns in the family that contribute to the child’s symptoms, regardless of whether they are dissociative.

Chapter 2 covers a comprehensive list of warning signs related to dissociative symptoms and behaviors, and contributing circumstances that can cause or influence the use of dissociation. These warning signs describe specific behaviors that include core dissociative symptoms of amnesia, hallucinations, memory disturbances, and presence of self-states, as well as co-occurring symptoms and behaviors that often mask dissociative presentations. The warning signs are illustrated by numerous clinical examples from my caseload. This chapter provides a broad framework that can inform clinicians to consider these signs and circumstances when evaluating traumatized children for early detection of and treatment for dissociation.

Chapter 3 continues to draw on Chapter 2 by specifically examining overlapping symptoms of dissociation with more commonly known diagnoses, and how this often leads to misdiagnosis of dissociation in children. A discussion occurs about how children with complex trauma can have multiple domains of impairment, leading clinicians to base their
diagnoses on the most florid symptoms, for example, inattention (attention deficit hyperactivity disorder [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. Research studies are critically examined to help the clinician discern the difference between overlapping symptoms found in other diagnoses and how they may actually be indicative of a dissociative disorder. It is stressed that recognizing these differences can lead to early detection of dissociation and a more promising recovery.

Chapter 4 provides a detailed description of areas of assessment; the use of valid, normative assessment tools; and careful, thorough questioning of the child and parents. This chapter introduces Rudy and Lisa, and it continues the discussion on Briana and Cathy. Many other cases are also described to provide examples of the diverse presentations that children can exhibit with dissociative behaviors. This chapter also provides guidance on how to question children about their dissociative behaviors.

Chapter 5 lays the groundwork for assessing and treating children with dissociation. It provides overarching principles of how to successfully work with traumatized children. A brief introduction into the phase-oriented treatment, beginning with stabilization and ending with integration, is provided. Special emphasis on developing metacognitive skills to help children reach integration is given.

Chapter 6 begins the description of the treatment process of dissociative children by focusing initially on the family and next on resolving attachment disturbances. I discuss the importance of building a secure attachment with parents or caretakers as an anchor for traumatized children to be able to release their dissociative defenses and face the horrors of their past traumatic life. Parenting strategies, formulated on brain-based parenting (e.g., Hughes & Bylin, 2012) and Satir’s (1983) approach to family systems, and strategies to manage dissociative symptoms are discussed. This framework provides the clinician with an integrative approach in managing the complexity of family work that will enhance treatment of the dissociative child. Challenges in working with families are discussed, and specialized techniques to engage the parents are offered. The chapter concludes with a description of a perplexing case of a “detached teenager” and the successful outcome.

Chapter 7 begins with the provocative case of Rudy ascribing his attempt to strangle his sister to his “invisible team.” This example sets the
stage for a discussion on how dissociative self-states can drive a child to behave in dangerous, erratic ways. I begin with defining classifications of “lion self-states,” perpetrating parts of a child that can wreak havoc on the child and his or her family’s life. Questions designed to assess such states are presented. My dialogue with Rudy is detailed to illustrate his internal world where cognitive errors formed from his early traumatic life in an East European orphanage. This chapter, Phase 1 of treatment, provides detailed strategies for stabilization that enhance internal awareness, cooperation, and communication, and offers empowerment techniques that lay the foundation for later trauma processing.

Chapter 8 builds on Chapter 7 by offering more detailed strategies for stabilization that specifically focus on calming the child’s overactive stress response system and managing triggers. Numerous exercises, such as containment, safe place/safe state, connecting with the body, building self-reflection (e.g., EARTH), and expanding the window of tolerance, are described. These techniques help equip the child with resources to be emotionally present and to be able to manage strong affect, particularly during trauma processing. Eight overlapping tasks are outlined to help the child manage triggers. Numerous case examples, including Cathy’s and Briana’s, are elucidated with the use of these strategies, including dialogues between the child and the therapist.

Chapter 9, which is coauthored with Adrian J. Stierum, is the first chapter since 1997 (Nemzer, 1998) that has been written on the use of medication in dissociative youth. Although medication will not cure dissociation in children, it is considered an adjunctive, time-limited therapy to help the child function until the trauma can be processed. This chapter follows the Clinical Manual of Child and Adolescent Psychopharmacology, second edition, edited by McVoy and Findling (2013), the official American Psychiatric Association (APA) guidelines, when discussing the use of medication. Numerous case studies illustrate specific symptoms and behaviors in which certain types of medication are useful. Cautionary guidelines for use, including side effects and health risks to the child’s developing brain, are also discussed with the emphasis on increasing treatment sessions and stabilization techniques prior to administering medication.

Chapter 10 begins with a quote, “When I think of the bad stuff, I don’t feel bad anymore.” This chapter, Phase 2 of treatment, describes nine guidelines of areas that are used to assess readiness for trauma processing, such as a child’s current level of comorbidity and use of stabilization techniques, evaluating meaning of implicit memories, and past
unresolved attachment. The remainder of the chapter involves detailed descriptions of four stories of children’s trauma processing using interventions tailored to their needs.

Chapter 11, coauthored with Diane Raven, is a description of a successful collaborative treatment effort between Raven, former art director at Great Lakes Recovery Center for Adolescents (a substance abuse residential program), and myself in providing intensive treatment for traumatized youth with comorbid substance abuse. Raven’s innovative, inspiring art therapy interventions are illustrated with step-by-step instructions and case examples. These interventions are designed to help traumatized adolescents describe their internal life and begin to face their traumatic past. The issues that arose in art therapy were then addressed in intensive psychotherapy provided by me. The case of Emily demonstrates how art therapy combined with individual and family therapy can hasten recovery. Reproductions of Emily’s art that depict each stage in her therapeutic process through integration are included.

Chapter 12 focuses specifically on the use of eye movement desensitization and reprocessing (EMDR) therapy with traumatized, dissociative youth throughout the treatment process. This chapter describes a comparison between adaptive information processing (AIP) theory and EMDR phases with dissociative theory and three-phase treatment of dissociative children. Details of each phase of treatment using EMDR therapy with emphasis on stabilization are provided. Numerous case studies illustrate the process with special emphasis on resolving early trauma with EMDR therapy.

Chapter 13, the final chapter, dealing with Phase 3 of treatment, focuses on integration techniques. This chapter opens with an eloquent description of what integration was like for a 10-year-old girl. Specific techniques to promote integration, including the use of metaphors (such as the child’s favorite dessert or sport), are detailed with case descriptions. Numerous detailed examples of the process of how children became integrated are provided. The book ends with guidelines for assessing integration, postintegration relapse, and, finally, an inspiring poem authored by an integrated child.

The aim of this book is to provide a solid basis for assessing and treating children with dissociation by providing rich clinical cases and specialized interventions that lead to trauma resolution and, finally, integration of the fractured child.
PART I

THEORY
The Star Theoretical Model
An Integrative Model for Assessing and Treating Childhood Dissociation

Children love and want to be loved and they very much prefer the joy of accomplishment to the triumph of hateful failure. Do not mistake a child for his symptom.
—Erik Erikson

This quote by Erikson resonates with the message I hope to convey in this book. Children are children and we must not define them by their symptoms. We need to look deep within them to see what they are truly communicating via their behavior and symptoms. Consider the symptoms of the following children:

At ten years old, Geraldine was found wondering in a dazed state with severe amnesia. She did not know who she was or where she was. She had a severe headache and realized that her mother was not with her (her mother had died 2 years earlier), and that she was on the wrong bus. (Bowlby, 1980, p. 338)

When Laura returned home, she banged on the door calling “Mummy, Mummy!” When her mother opened the door, Laura looked at her blankly and said, “But I want my mummy.” For the next two days Laura seemed not to recognize her mother and, although not unfriendly, was completely detached. (Bowlby, 1980, p. 409)

During Kate’s second week of placement in foster care, she expressed fear of getting lost, was clingy, cried more easily and at times seemed preoccupied and dreamy. On one such occasion, she murmured, “What is Kate looking for?,” a remark that seemed to indicate that she was temporarily losing track of the identity of the
person for whom she was yearning and searching. (Bowlby, 1980, pp. 395–396)

Remarkably, these brief case descriptions are not from research on dissociation, but rather from a study by John Bowlby, the father of attachment theory, on the impact of maternal losses on children. Bowlby (1980) noted that after being separated from their mothers, many children demonstrated profound detachment from their mothers who, in turn, complained that their children treated them as strangers. Bowlby described these children as having blank looks on their faces, confusion about their identity (e.g., Kate referring to herself in the third person), and apparent amnesia for their mothers after periods of separation. The symptoms he described are currently recognized as dissociative responses resulting from pronounced relational losses at an early age.

In the mid-1990s, I had been treating dissociative children for a decade and recognized that a comprehensive theoretical model was needed to understand the complexity and nuances of the multiple influences that impact traumatized children’s reliance on dissociation. One theory seemed insufficient to explain dissociative symptoms in traumatized children, but a combination of theories from different fields provided a comprehensive framework for accurate assessment and successful treatment. I therefore developed the Quadri-Theoretical Model (Waters, 1996), which interlinked four prominent theories—attachment, child development, family systems, and dissociation. This model has recently been revised to include neurobiology as the fifth theory and is now called the Star Theoretical Model (STM; Figure 1.1).

The model describes pathways that either lead to or influence the use of dissociation in children and adolescents, and it guides the assessment and treatment of children with dissociation. The star shape represents the children who are exposed to trauma. This is not to say that all traumatized children utilize dissociation or develop a dissociative disorder. Rather, the STM was developed to describe pathways in those situations in which children do develop dissociation. The attachment theory was intentionally placed at the top of the star to signify the paramount role that parent–child attachment plays in contributing to a child’s reliance on dissociative coping mechanisms when traumatized. The strength of the parent–child attachment bond also influences the child’s ability to heal.

It is important to note that although each of the five theoretical models describes significant dynamics pertaining to development of dissociation
in children, it is the integration of the five theories that formulates my diagnostic and therapeutic approach. Prior to explaining my model, I describe dissociation and examine the etiology of dissociation from different theoretical perspectives.

**DEFINITION OF DISSOCIATION**

Currently, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* defines dissociation as a disturbance in the ongoing continuity in the normal integration of consciousness, memory, identity, emotional, perception, body representation, motor control, and behavior (American Psychiatric Association [APA], 2013, p. 291). Dissociation occurs on a continuum ranging from nonpathological or normal dissociation to pathological dissociation. Examples of normal dissociation are absorption, such as when reading a thrilling book or playing video games, daydreaming about something pleasant, or “highway hypnosis,” such as losing track of time when driving on a long stretch of highway.

The distinguishing characteristic between nonpathological and pathological dissociation is that pathological dissociation comprises some
degree of a “structural division” within the self, causing disturbances in consciousness, memory, perception, and/or identity. For example, someone may think about a traumatic event, yet feel detached or numb (depersonalization), or may view the event with some distortion (derealization), such as a tunnel vision. In its most severe form, dissociation may manifest as segregated self-states with separate states of consciousness or awareness. Self-states (also called parts, ego states, or alters) are segmented states of consciousness within the child that may present as different beings that can either take executive control of the child’s body or influence the child from within. These states are instinctively created to carry unwanted, disturbing traumatic-associated material (e.g., affect, behavior/function, sensations, and/or memories) so the child can survive intolerable circumstances. Self-states can perform necessary functions for the child when the child is unable to cope; the child may view himself or herself as having a different age, gender, and viewpoint from those of the presenting child–client. These states can present in therapy as distinct changes in affect, speech patterns, demeanor, and body language, and each state may respond differently to the therapist (see International Society for the Study of Trauma and Dissociation [ISSTD] FAQ\(^1\)). For a list of some Internet sites on child trauma and dissociation, refer to Appendix A.

**Relationship Between Trauma and Dissociation**

There are abundant research and clinical cases describing the traumatic impact of sexual abuse (e.g., Hulette, Fisher, Kim, Ganger, \& Landsverk, 2008; Kisiel \& Lyons, 2001; Kisiel, McClelland, \& Torgersen, 2013; Macfie, Cicchetti, \& Toth, 2001), physical abuse (e.g., Chu \& Dill, 1990; Chu, Frey, Ganzel, \& Matthews, 1999), emotional abuse (e.g., Teicher, Samson, Polcari, \& McGreenery, 2006), emotional neglect (e.g., Milot et al., 2013), and natural disasters (e.g., Vásquez et al., 2012) on the development of childhood dissociation. In many of these studies, children experience more than one type of trauma.

Kisiel and Lyons (2001) studied 114 youth (10–18 years of age) who were wards of the Illinois Department of Children and Family Services and resided in residential treatment centers. Their results suggested a unique relationship between sexual abuse and dissociation. They concluded that dissociation may be the critical mediator of psychiatric symptoms and risk-taking behavior among sexually abused children. Another
study found a significant correlation between sexual abuse, physical abuse and neglect, and higher levels of dissociation in foster children in San Diego (Hulette et al., 2008). Cloitre et al. (2009) researched the cumulative effects of traumatic exposure in clinical samples of 582 women and 152 children and found a direct relationship between the number of traumatic experiences and complex symptoms, including dissociation and overall self-regulatory disturbance.

The relationship between trauma and dissociation has been demonstrated cross-culturally in many different countries, including England (Farrington, Waller, Smerden, & Faupel, 2001), Turkey (Zoroglu, Sar, Tuzun, Tutkun, & Savas, 2002), the Netherlands (Muris, Merckelbach, & Peeters, 2003), Sweden (Nilsson & Svedin, 2006), and Finland (Tolmunen et al., 2007). Sar, Onder, Kilicaslan, Zoroglu, and Alyanak (2014) studied the prevalence of dissociation in a psychiatric outpatient sample in Turkey and found that of the 73 adolescents examined, 45.2% had a dissociative disorder, 16.4% had dissociative identity disorder (DID), and 28.8% had dissociative disorder not otherwise specified (DDNOS). A large Japanese study surveyed 1,993 schoolchildren between 11 and 18 years of age and found that 15% of children had evidence of pathological dissociation (Yoshizumi, Hamada, Kaida, Gotow, & Murase, 2010).

Infant Trauma and Dissociation

A particularly pernicious form of trauma is infant trauma. Infants can be negatively impacted by a number of experiences, such as birth trauma; painful medical procedures; early deprivation; physical, sexual, and emotional abuse; and disruption in attachment. Traditional definitions of trauma may fail to recognize that infants’ symptoms relate to traumatic experiences. This may be due to the myth that infants and toddlers are either “resilient” or unaffected by traumatic events. In reality, the younger the children are when they experience trauma, the more likely they are to suffer enduring and pervasive problems (Perry, 2006). Although infants’ pain has been either discounted or unrecognized as causing disturbance, Gaensbauer (2002) noted that newborns manifest all of the cardinal physiologic stress responses to pain. Fraiberg (1982) succinctly states that it is not possible to say that infants do not experience trauma and are “too young to feel or remember” (p. 612).

Just because infants do not have the ability to verbalize their experiences, their sensory connections are functioning even before birth.
Infants are able to hear their mother’s voice and are influenced by their mother’s emotional state. In addition, the implicit memory system is always operating—calculating and tabulating sensory experiences. Infants do register emotional and physical pain. Although these memories may not be conscious, they are held in the implicit memory system and often manifest somatically and behaviorally. Bowlby (1980) and Fraiberg (1982) observed infants who experienced maternal separation and deprivation, and found that they demonstrated freezing behaviors, trance states, and memory problems, resulting in total disorganization. The most potentially terrifying experiences for a young child occur in the context of their primary attachment figure, usually a parent who is abusive or neglectful (Alexander, 2013), on whom the child is totally dependent. The child has no ability to escape the trauma, except by dissociating, an automatic, primitive response, as described in the Polyvagal Theory section by Porges (2011). Further research described a disorganized attachment style in infants that is characterized by dissociative behavior resulting from exposure to frightening parents and/or frightened parents (Main & Hesse, 1990; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997). However, today, many clinicians fail to recognize these as dissociative behaviors related to traumatic experiences and instead ascribe them to other diagnoses.

In summary, these studies point to the need to take a comprehensive trauma history and assess all children, including infants, for dissociation whenever they come to the attention of mental health professionals.

Conceptual Models of Dissociation

Since the early 19th century, a number of models have emerged that conceptualize the formation and treatment of dissociation. All these models are based on the premise that pathological dissociation derives from traumatic experiences. I incorporate many of these models into my conceptualization of dissociation as well.

Janet’s Concept of Dissociation

Although there are other early contributors to our understanding of dissociation (i.e., Ferenczi, 1933/1949; Freud, 1893/2001), Janet’s concepts have greatly influenced our current understanding of dissociation (see, e.g., van der Hart, Nijenhuis, & Steele, 2006; van der Kolk, van der Hart, & Marmar,
Janet (1907) used the term *hysteria* to refer to an individual’s retraction of his or her field of consciousness, with segregated internal systems, each with their own sense of self. Janet recognized the role of traumatic experiences in an individual’s constitutional vulnerability and integrative failure (van der Hart & Dorahy, 2009). Janet also recognized the intrusiveness of traumatic memories, which may be automatically replayed when activated, along with the fact that, at times, the individual may be unable to recall the traumatic memories (van der Hart & Dorahy, 2009). To treat hysteria, Janet developed the phase-oriented treatment model, which has been carried over into contemporary practice guidelines (ISSTD, 2011).

**Putnam’s Defense Model and Discrete Behavioral States**

Putnam (1997) defined *dissociation* as a complex psychophysiological process that alters the accessibility of memory and knowledge, along with the integration of behavior and a sense of self. Putnam (1997, pp. 67–75) views dissociation as a defense mechanism with three major tasks: (a) the automatization of behavior in the face of psychologically overwhelming circumstances; (b) compartmentalization of painful affects and memories; and (c) estrangement from self in the face of potential annihilation. The mind becomes overwhelmed with fear, and the child functions on an automatic pilot—going through the experience without conscious thought or feeling. The child is not fully aware of what she is really experiencing and may become numb or depersonalized (“It’s not me”). The child can compartmentalize either parts or all of the experience across affect, behavior, sensation, and memory, because facing it would overload the child’s coping abilities. Holding the trauma in one’s conscious memory would present a dangerous dilemma, particularly if a child depends on the abuser for care. It is safer for the child to not know or not to feel. Although separating from the trauma is adaptive, this separation of the self impairs the process of developing internal self-awareness and mindfulness.

Putnam’s (1997) Discrete Behavioral States Model views self-states as discrete states of consciousness, each with “…a specific and unique configuration of a set of psychological, physiological, and behavioral variables” (p. 152). The term *discrete behavioral states* originates from the study of infant behavioral states (Wolff, 1987) as infants transition from one activity to another (e.g., sleeping to waking; distressed to neutral). How the child responds to these behavioral states is dependent on his mother’s ability to read his cues and appropriately respond to his needs. For example, if
the mother responds to her infant in a calm, predictable, nurturing manner, then templates are created for the baby to have a smooth transition from one behavioral state to another. Smooth transitions help the infant to modulate affect between behavioral states. However, if the mother is unpredictable, confusing, frightening, or abusive, then the child will develop fear-based alterations of behavioral state pathways, leading to discrete behavioral states of dysregulated affect and behavior separated in consciousness or knowledge of other states.

Putnam defines *pathological dissociation* as “... a category of trauma-induced discrete behavioral states that are widely separated in multidimensional state space from normal states of consciousness” (p. 173). Treatment interventions include working with the child’s discrete states of consciousness, facilitating modulation between them, developing integrative functions across self-states, and resolving traumatic memories.

**Structural Dissociation**

Van der Hart et al. (2006) developed the theory of Structural Dissociation, which builds on the early works of Jackson (1931/1932) and Janet (1907). Their theory recognizes that trauma-related dissociation involves the personality having at least two self-organizing systems of psychobiological states. Each self-organizing system has its own sense of self that lacks integrative functioning between the other systems. Structural dissociation of the personality is composed of actions systems that are goal directed, adaptive, and defensive. These action systems are divided into the “apparently normal” personality (ANP) and the “emotional” personality (EP). The ANP is involved in managing daily life, such as working and attending school. The ANP is associated with avoidance of the traumatic memories, and if they have some knowledge of them, they experience detachment, as if it did not happen to them. The EP contains the traumatic memories, and associated traumatic affect, thoughts, behaviors, and sensations. The EP remains fixated at the time of the trauma and is dedicated to the survival from “predatory” threat. It often becomes stuck in the sensory experience of the traumatic memory and is unaware of the passage of time. With severe, chronic trauma, each ANP and EP can further divide into many ANPs and EPs that take on additional actions for the self.

The Structural Dissociation Model has mainly been used with adults but has also been found to be useful in understanding dissociative children (see Stolbach, 2005; Wieland, 2015a). It provides a framework for
conceptualizing different self-states in children, which are viewed as action systems that are formed to help the child survive. Treatment involves evaluating each action system and then breaking down amnestic barriers between systems as the trauma is processed and resolved so that integration can occur.

_Ego State Theory_

Watkins and Watkins’s (1997) ego state theory conceptualizes ego states along a continuum from normal to pathological. They define an _ego state_ as “...a body of behaviors and experiences bound together by some common principle and separated from other such entities by boundaries which are more or less permeable” (Watkins & Watkins, 1988, p. 69). The ego state theory recognizes a range of boundaries between ego states varying from normal to pathological, such as impermeable barriers resulting in amnesia between the ego states. When clients have impermeable boundaries, they are considered to have an ego state disorder. Impermeable boundaries between ego states usually occur as a survival response when children are confronted with overwhelming trauma. These pathological ego states can have a sense of separateness, assume executive position, be highly motivated to protect their existence, and be in conflict with other ego states or the primary person. Ego states can contain affect (e.g., sad, mad, scared) or behavioral roles (playful, student, abuser). They can also identify with someone important to the child (e.g., nonabuser or abuser, aunt, hero figure). Treatment involves individual therapy to reduce the rigidity of the boundaries between states, lessening conflicts between ego states, and promoting mutual understanding through interstate communications (Watkins, 1993).

_Affect Avoidance Theory_

Affect avoidance theory (Silberg, 2013) relies on developmental literature, including Putnam’s Discrete Behavioral States Model, attachment theory, affect theory, and interpersonal neurobiology, to explain how and why traumatized children develop dissociative coping strategies. The affect avoidance theory views dissociation as an adaptive response to trauma. Silberg noted that if the child experiences terror or distress in connection with the caregiver, the affects aroused are often intense. Over time, the affect itself becomes so painful that avoidance programs take over,
triggering automatic defensive behaviors that may have been learned at a time and place when it was adaptive to engage in these behaviors. The mind becomes organized around shifting identities or self-states that segment the intense affect off from awareness. Silberg (2013) defines *dissociation* as follows: “The automatic activation of patterns of action, thought, perception, identity, or relating (or ‘affect scripts’), which are overlearned and serve as conditioned avoidance responses to affect arousal associated with traumatic cues” (p. 22).

According to Silberg (2013), it is the reactivation and repetition of this pattern that develops rigidity within traumatized children, causing memory problems, fluctuating behaviors, shifts of consciousness, shifting identities, and somatic disturbances. The rigidity and impermeability of these affect scripts, stimulated by multiple triggers in the environment, make them highly resistant to intervention. These patterns of responding may become organized as shifting identities or self-states.

From this perspective, the treatment of dissociative states requires an interpersonal process that changes the restrictive ways in which the mind has come to organize itself. It requires the presence of an attuned therapist and an engaged family. Treatment emphasizes avoiding trauma-based cues and attending to select information from the environment that facilitates increasing self-determination and freedom from automatic responses learned in the traumatic past.

**Betrayal Trauma**

Betrayal trauma theory (Freyd, 1996) builds on the attachment theory to explain why dissociative amnesia can be an adaptive survival mechanism. The theory posits that betrayal by a trusted caregiver is the core factor in determining the use of dissociative defenses and developing memory deficits for childhood trauma. Freyd proposes that humans are sensitive to betrayal, and when one is betrayed, the normal reaction is to feel pain and avoid further contact with the betrayer. However, when attachment processes are involved, such a response may not be in the victim’s survival interests. If abused children processed betrayal by an essential caregiver in the normal way, they would be motivated to stop interacting with the betrayer. However, if a child was to withdraw from a caregiver on whom he or she is dependent, the child’s life would be placed in even greater danger. As Freyd points out, “A child who distrusts his or her parents risks alienating the parents further, and thus becomes subject to more
abuse and less love and care” (p. 10). In these circumstances, Freyd (1996) suggests that the need to survive may prevail over the need to avoid betrayal. Consequently, victims of intimate betrayals learn to cope with inescapable conflict through internal disconnection (i.e., dissociation), rather than through external avoidance. Thus, the betrayal trauma theory posits that violence perpetrated by someone on whom the victim is dependent will be associated with memory disruption, dissociation, and other cognitive dysfunctions in order to help the victim maintain the necessary, albeit abusive, attachment (see Freyd, 1996).

Summary

All of these models recognize the need to break down amnestic barriers between parts of the self, be they ego states, self-states, or action states, and each of these models has informed my work. The betrayal trauma theory plays a significant role in the STM (described next), particularly under attachment, when I compare Bowlby’s (1960) five stages of psychological responses to grief and mourning with similar stages that dissociative children experience from interpersonal violence. Let us examine the model I developed to assess and treat childhood dissociation.

THE STAR THEORETICAL MODEL FOR ASSESSING AND TREATING CHILDHOOD DISSOCIATION

The STM integrates five prominent theories—attachment, neurobiology, developmental theory, family systems, and dissociation—to describe pathways that lead to or influence the use of dissociation in children and adolescents. It complements the prior theories of dissociation outlined earlier; however, my theory relies more heavily on the interlinking between attachment, child development, neurobiology, and family system theories.

Dissociation: A Creative Escape Hatch

Houdini, an escape artist and stunt performer, was a master at devising illusions that made animals and people disappear (Gibbons, 2014). Our logical sense said that they could not really disappear—that he must be
using a trapdoor of some kind. Houdini became popular, because his
tricks defied all reason and left audiences in awe as the trapdoor was so
well concealed.

In many respects, dissociation is a secret trapdoor that allows a child
who cannot physically escape from a terrifying experience to mentally
exit the situation. However, dissociation is not a trick. It is an instinctive,
biological survival mechanism (Porges, 2011) involving immobilization
and freezing that is activated when the threat is so great, and the fear is
so overwhelming, that the child feels death is imminent (Putnam, 1997).
The child escapes the only way that affords him or her the ability to be
able to go on with life. The child separates from the experience so that “it
didn’t occur,” “it didn’t happen to me,” or if it did, “it didn’t bother me.”
It is an automatic escape hatch that can be activated so the child does not
have to know when knowing is too unbearable. The child may at times
know bits and pieces of the trauma; at other times, the child may not even
know that it occurred! Although dissociation is adaptive at the time of the
trauma, later, it can interfere with the child’s effectiveness in navigating
the world.

An example of how dissociation can manifest in a child can be found
in the case of Kaitlyn, a 5-year-old girl abused by her stepbrother, Charlie.
Kaitlyn eloquently described dissociation when referring to an internal-
ized abusive self-state she called “Charlie.” Kaitlyn chose a puppet of an
alien to represent the Charlie voice inside of her head. She put her small
hand in the puppet and exclaimed, “It’s all Charlie’s fault!” I motioned
with a hermit crab puppet asking, “What do you mean it is all Charlie’s
fault?” She pounded the alien puppet’s head with her free hand and said,
“That mean Charlie makes me do bad things.” I asked her what kind of
bad things he made her do. Kaitlyn looked a bit perplexed and answered,
“I can’t remember.” I responded, “You know he makes you do bad things,
but you can’t remember?” She nodded her head in agreement and added,
“But I know one thing, he gets louder, louder and louder, and then he
shoves out!” as she raised her head upward. I reflected her words, “He
makes you do bad things and he shoves out. What happens next?” She
looked at me, pondering a moment and then said, “He gets louder and
louder and then my mind walks away and he’s in my mind!” I responded,
“He gets louder and louder and then your mind walks away and he is in
your mind. What happens then?” She shrugged her shoulders, again look-
ing perplexed, and answered, “I don’t know.”
Kaitlyn innocently and yet poignantly disclosed what dissociation is like. She related how Charlie hijacks her mind as he “gets louder and louder” and she then did not know what happened next. It was confusing and frightening for Kaitlyn to be plagued by a threatening, persistent voice telling her to do bad things, for which she has no control and no memory once “he shoves out.”

The mechanism by which traumatized children are able to develop different self-states appears to be a creative way to escape from unmitigated terror, helplessness, confusion, and emotional and physical pain. It certainly surpasses any of Houdini’s tricks. At the same time, the existence of self-states with different genders, ages, and roles can seem unimaginable and hard to comprehend. Putnam (1997) stated, “Alter personalities are real. They do exist, not as separate individuals but as discrete dissociative states of consciousness. When considered from this perspective, they are not nearly so amazing to behold or so difficult to accept” (p. 90, italics added). Putnam then quoted Coons (1984), who stated, “Only when taken together can all of the personality states be considered a whole personality” (p. 90).

Let’s examine next the neurobiology of trauma.

Neurobiology: Impact on Memory and Fragmentation

Although we can listen carefully to what traumatized children tell us about memory disturbances, observe them, and make conjectures about what is happening inside them, new neurological discoveries provide some scientific answers. There are many neurobiological systems operating within each of us to ensure our survival and development. Understanding these systems can provide some insight as to memory disturbances and the development of dissociation and self-states.

Numerous researchers have recognized the impact of chronic traumatic stress on memory and brain structures (e.g., hippocampus, amygdala, prefrontal cortex, corpus callosum) (Bremner, 2005; DeBellis et al., 1999; Frewen & Lanius, 2006; Nijenhuis & den Boer, 2009; Reinders et al., 2003; Vermetten, Schmahl, Lindner, Loewenstein, & Bremner, 2006). Stress can lead to the deactivation of certain critical structures in the brain that encode and consolidate memories into the conscious memory system, accounting for memory problems and dissociative responses (Bremner, 2005; Perry, 2001; Vermetten et al., 2006).
A recent study has confirmed a neurological pathway for inaccessible traumatic memories (Jovasevic et al., 2015). Memories are usually stored in distributed brain networks and can be readily accessed to consciously remember an event. A process known as state-dependent learning is believed to contribute to the formation of memories that are inaccessible to the normal consciousness. This process has received empirical support from Jovasevic et al.’s study.

To better understand the mechanisms underlying state-dependent fear, the researchers used a mouse model of contextual fear conditioning. Glutamate is the primary chemical that helps store memories across distributed brain networks. Glutamate and gamma-aminobutyric acid (GABA) work in tandem to control levels of excitation and inhibition in the brain, and, under normal conditions, remain balanced. Hyperarousal, which occurs when we are terrified, causes glutamate to surge. GABA, on the other hand, is calming and balances glutamate receptors in the presence of stress. However, extra-synaptic GABA receptors also exist. Based on prior research, Jovasevic et al. hypothesized that the ability to remember stressful experiences might be mediated by extra-synaptic GABA receptors in the brain.

To test this, Jovasevic et al. gave mice a chemical, gaboxadol, with extra-synaptic GABA receptors that induce a state similar to mild inebriation. The mice were then placed in a box and given a brief, mild shock. The next day, the mice were placed in the same box without the chemical administered beforehand. The mice moved about freely, unafraid, indicating they did not recall the shock. Later, the mice were given the chemical and again placed in the box. This time when they entered the box, they froze in fear anticipating another shock. Thus, when the mice were returned to the same brain state they were in when they received the shock, they remembered it.

The study demonstrated that when the extra-synaptic GABA receptors were activated with the drug, they changed the way the stressful event was encoded. Extra-synaptic GABA\(_A\) receptors promoted subcortical, but impaired cortical, activation during memory encoding of the fearful event. Thus, the brain rerouted the memory using completely different molecular pathways and neuronal circuits to store the memory. The researchers said their findings imply that in response to trauma, some people will not activate the glutamate system but instead activate the extra-synaptic GABA system (Scutti, 2015).

According to one of the researchers, Jelena Radulovic, “The brain functions in different states, much like a radio operates at AM and FM
frequency bands” (ScienceDaily, 2015). She noted that it is as if the brain is normally tuned to FM stations to access memories, but needs to be tuned to AM stations to access traumatic memories. The memory of the traumatic event cannot be accessed unless the same neural pathways are activated once again, essentially tuning the brain back into the AM stations. This research provides insight about how self-states can coexist with different memories and emotions.

Furthermore, studies have demonstrated neurobiological differences in self-states of DID patients. Reinders, Willemsen, Vos, Den Boer, and Nijenhuis (2012) looked at self-states with brain imaging. They found striking neurobiological differences in authentic self-states in DID patients compared with a control group of healthy high and low fantasy-prone adults simulating self-states in role-play. In reviewing brain imaging studies, Frewen and Lanius (2006) found that dissociation involves a disconnection in the neural pathways usually linking self-awareness with somatosensory awareness, which could lead to the development of dissociative identities in traumatized children.

**Polyvagal Theory**

The autonomic nervous system (ANS) also plays a role in dissociation. This system works automatically without a person’s conscious effort. Stephen Porges, originator of the polyvagal theory, has extensively studied the ANS, a neuroendocrine–immune structure that enables survival. The ANS innervates the internal organs (e.g., the heart and digestive system) and regulates their functions. It was previously believed that the ANS had two main divisions: sympathetic and parasympathetic. For the most part, the sympathetic nervous system stimulates body processes (e.g., increases the heart rate) and the parasympathetic inhibits body processes (e.g., slows the heart rate). However, Porges (2011) discovered a third branch of the ANS, which he calls the social engagement nervous system, that promotes connections to others through responding to interpersonal cues.

According to Porges (2011), these three branches of the ANS produce phylogenically ordered responses that are instinctual and unconscious. The most primitive branch of the ANS is the parasympathetic nervous system. It is associated with primal survival strategies of primitive vertebrates, reptiles, and amphibians and remains functional in humans. It encompasses the unmyelinated portion of the vagus nerve that regulates the digestive and reproductive systems, and it creates a metabolic baseline
of operation to manage nutrients getting to the cells. When activated by fear, it initiates a shutdown response involving immobilization, feigning death, and/or dissociation. Above in the evolutionary chain is the sympathetic system that enables mobility for finding food and defending against threats. It is responsible for fight or flight behaviors. The most advanced branch of the ANS is the social engagement system. It is mediated by the myelinated portion of the vagus nerve and fosters social communication and maternal bonding via facial expressions, vocalization, and listening.

Porges quotes Jackson’s theory of dissolution (1958), which explains diseases of the nervous system: “The higher nervous system arrangements inhibit (or control) the lower, and thus, when the higher are suddenly rendered functionless, the lower rise in activity” (Jackson as cited in Porges, 2011, p. 162). For example, when an individual is under threat and cannot be rescued, the most recent section of the ANS from an evolutionary standpoint, the social engagement system, shuts down. The sympathetic nervous system is then automatically activated. It increases the heart rate and pumps blood to the muscles, preparing the individual to either fight or flee. If it is not feasible for the individual to defend himself or herself, then the sympathetic nervous system shuts down and the most primitive portion of the ANS, the parasympathetic nervous system, is activated and initiates a freeze response. As a last resort for survival, it causes a general shutdown of the body, leading to immobilization, feigning death, and/or dissociation.

This hierarchical functioning of the nervous system explains survival strategies often observed in abused children. For example, when a child is abused by a caretaker, the social engagement response is violated and cannot function. The child is unable to seek support. Further, when the vulnerable child is unable to defend himself or herself by fighting or fleeing, the child will revert automatically and instinctively to the most primitive response: immobilization and dissociation.

**Use-Dependent Development of the Brain**

A theoretical work by Bruce Perry, a psychiatrist who has done extensive research on traumatized children, provides a conceptual framework for understanding how childhood trauma can result in long-term changes in the functioning of children’s nervous systems. Perry’s model explains how over time transitory states can become enduring traits. According to Perry,
Pollard, Blakely, Baker, and Vigilante (1995), repetitive neural activation caused by repeated exposure to threatening stimuli causes sensitization of the nervous system. The more a neural network is activated, the more there will be use-dependent internalization of new information needed for survival. Perry et al. explained, “The more frequently a certain pattern of neural activation occurs, the more indelible the internal representation” (p. 275).

This use-dependent activation can be viewed as a template through which future input is filtered. Use-dependent internalization of a state of anger or fear, for example, may explain how children can have certain self-states that they identify as “the fearful one,” or “the angry one.” Perhaps this may also explain self-states that identify with the perpetrator or with hero characters, as children may internalize representations of these figures when they are abused. Over time, these internal representations are reinforced and become self-states that are activated whenever trauma-related cues are present. Due to sensitization, stress-induced activation of these internal representations can be elicited by decreasingly intense stimuli, resulting in the child developing hyperarousal or dissociative reactions in response to minor stresses (Perry et al., 1995).

**Mirror Neurons**

An understanding of why traumatized children may mimic or take on certain characteristics of others, including the mirroring found in self-states, can be explained by the discovery of mirror neurons in the brain (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996; Rizzolatti, Fadiga, Gallese, & Fogassi, 1996). While studying macaque monkeys, researchers found that when one monkey was grasping for food and another monkey was observing it with the intention to grab food, the identical neurons fired in both monkeys. Iacoboni (2009) noted that core circuitry in mirroring is the superior temporal cortex, inferior parietal lobule, and inferior frontal cortex.

This landmark discovery has increased our understanding of human interactions, including facial imitation, perception, and action (Casile, Caggiano, & Ferrari, 2011). Iacoboni (2009) found evidence to suggest that there are mirror neurons that code facial actions. This innate ability to imitate others may help us better understand the people around us. According to Iacoboni, mirror neurons “provide a prereflective, automatic
mechanism of mirroring what is going on in the brain of other people that seems compatible with our ability to understand others effortlessly and with our tendency to imitate others automatically . . .” (p. 658). Children who are dependent on others for survival, particularly their parents, often seek to mimic them. Iacoboni hypothesized that children may be prewired to imitate their parents in order to gain their favor.

Mirror neurons and children’s desire to imitate and please caregivers who may also be abusive have implications for dissociation. When parents vacillate from being nice to being abusive, the child who is prewired to mirror is in a double bind. The child may deal with this bind by developing self-states that mimic the different presentations of their parents to manage contradictory working models of attachment (see Blizard, 2003). The presence of a prewired system to mirror others may also explain why traumatized children internalize self-states that mimic cartoon heroes they watch repeatedly on television or pet animals from whom they receive comfort. I have had a number of children who had self-states that were hero figures or pet animals. Animal self-states were often internal representations of a beloved pet that was either killed by the child’s abuser or that had comforted the child when abused.

Attachment Theory

... [M]other-love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health.

—John Bowlby (1953, p. 182)

The attachment portion of my model is primarily derived from the works of Bowlby, along with the findings of other researchers who have built on his work (e.g., Main & Hesse, 1990). Attachment is described as an emotional bond to another person. Bowlby (1982b) indicated that attachment is an enduring psychological connectedness between human beings. He defined attachment behavior as an instinctual drive of the infant to connect to the parent for survival. It is any behavior that the person engages in from time to time to obtain or maintain a desired proximity, particularly during times when security and closeness are needed to cope with challenges (Bowlby, 1982a). Attachment and attachment behavior are dynamics operating within the life span of the individual. Knowing that the attachment figure is available and responsive provides security for the individual. The lack of a lasting attachment or attachment bond can have
a profound impact on the child’s personality development, causing the child to be disturbed.

A secure attachment is formed through a repetitive interplay between mother and child in which the mother is in attunement with her child and the child’s needs are met with consistent nurturing responses. Bowlby (1980) believed that the formation of a secure attachment with the mother in a child’s early years provides the child with the capacity and confidence for managing stress and developing intimacy with others. Thus, the mother lays the foundation for the child’s ability to form other relationships. The mother also becomes the regulatory mechanism for the child’s own expressions and thus helps the child manage transitions.

Recent contributions from neuroscience support Bowlby’s assertions that attachment is instinctive behavior with a biological function, that emotional processes lie at the foundation of a model of instinctive behavior, and that a biological control system in the brain regulates affectively driven instinctive behavior (Schore, 2000). Schore stated,

...attachment experiences, face-to-face transactions of affect synchrony between caregiver and infant, directly influence the imprinting, the circuit wiring of the orbital prefrontal cortex, a corticolimbic area that is known to begin a major maturational change at 10 to 12 months and to complete a critical period of growth from the middle to the end of the second year. This time-frame is identical to Bowlby’s maturation of an attachment control system that is open to influence from the developmental environment. (p. 30)

Schore (2000) noted that the circuit wiring of the orbital frontal system rapidly evaluates environmental stimuli and monitors the internal state with the purpose of managing environmental disturbance. According to Schore, “Attachment theory is essentially a regulatory theory, and attachment can be defined as the interactive regulation of biological synchronicity between organisms” (p. 23). It is through this interplay (whether positive or aversive) that the child develops internal working models of representation of the self and an attachment figure (Bowlby, 1973).

Ainsworth, Blehar, Waters, and Wall (1978) originally identified three attachment classifications—secure, avoidant, and ambivalent. However, Main and Solomon (1986) recognized a new attachment classification, disorganized attachment, that has significance to this discussion. Main and Solomon found that toddlers reacted in a disorganized manner toward
their mothers who were frightened or exhibited frightening behavior (e.g., abusive, neglectful, contradictory, or intrusive) toward them. Infant disorganized attachment behaviors bear close resemblance to clinical phenomena that are usually regarded as indicative of dissociation (Hesse & Main, 2000). The children would extend their arms to their mothers while also turning their heads away in the middle of approaching their parents. They would suddenly become immobile and unresponsive with a blank look on their faces and then collapse. Children with disorganized attachment show contradiction in movement patterns, as if they are pursuing two incompatible goals simultaneously (Liotti, 2004, p. 5). Main and Hesse (1990) argued that parents who act as figures of both fear and reassurance to a child contribute to a disorganized attachment style. These children are unable to develop an organized style of attachment, as their maltreating parents confront them with an inescapable paradox: The parents are potentially the only source of comfort for their children, while simultaneously frightening their children through their abusive behavior.

Disorganized attachment behaviors are considered indicators of trauma-induced stress and anxiety. Studies conducted by Carlson, Cicchetti, Barnett, and Braunwald (1989), as well as by Lyons-Ruth (1996) found that almost 80% of infants in maltreatment samples show evidence of a disorganized attachment style. Numerous clinicians and researchers have recognized the significance of attachment disorders to the development of dissociation (Barach, 1991), particularly disorganized attachment (Liotti, 1999, 2004, 2006, 2009; Lyons-Ruth, 2003; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006; Lyons-Ruth & Spielman, 2004; Main & Hesse, 1990; Ogawa et al., 1997; Schore, 2000, 2009; Siegel, 1999). Blizard (2003) noted that disorganized attachment forms the basis for individuals who were abused by their parents and developed alternating, self-states with incompatible, idealizing/devaluing, or victim/persecutor models of attachment.

An example of how dissociation can affect attachment relationships can be found in the case of Becky. This case also shows how a self-state can become a container for negative affect associated with abuse and threaten the child’s attachment to her nonabusive caregivers. Becky, a pleasant and cooperative child, had a secure attachment to her parents until she entered kindergarten. After starting school, her demeanor dramatically shifted and she would display fits of anger, refuse to wear her favorite clothes, and act detached from her parents. After Becky disclosed that her male school bus driver had been sexually abusing her after all the other children had been let off the bus, she was brought to me for therapy.
When I asked Becky about the dramatic changes in her behavior, she reported hearing an angry, harassing, male voice that frightened her. At the same time that she heard the voice, inside her mind she would see a face with “mean, red eyes.” The voice told Becky she was stupid. Becky said that he would take control over her. This angry part had completely different clothing preferences than Becky. He was responsible for her negative thinking and uncontrollable rages. In addition, he was not attached to her parents, which profoundly impacted Becky’s relationship with them. It appeared that the state held Becky’s rage regarding her abuse. Becky drew a picture of herself with wide, vacant eyes and a large red mouth opened wide, depicting her terror both over the abuse and over the angry part inside her. She wrote, “I am really scared” (Figure 1.2).

Becky’s dissociative escape strategy was to completely segment herself off from the repetitive, terrifying experience. In doing so, she developed a part that only knew rage and eventually turned it on her. Becky’s parents had noticed a dramatic change in their daughter but were completely baffled as to what was going on until she finally disclosed what had been transpiring daily on her school bus. Once she disclosed the

Figure 1.2  Becky’s drawing of how scared she was. (Used with permission.)
existence of a self-state that would completely take control over her mood and behavior, her parents were finally able to understand their daughter’s complete personality transformation and be supportive of her.

**Bowlby’s Research on Children Separated From Their Mothers**

Bowlby, who believed in cross-fertilization between research and therapy, made systematic observations of children separated from their mothers with the help of his assistant, James Robertson, a trained observer. Robertson filmed young children in residential nurseries or hospitals to track their responses regarding separation from their mothers during their stay. The results were groundbreaking and relevant to contemporary science on trauma and dissociation. Bowlby (1980) noted that after separation from their mothers for extended periods, many children demonstrated profound detachment from their mothers, who, in turn, complained that their children treated them as strangers. Bowlby described these children as having blank looks on their faces with apparent amnesia for their mothers after periods of separation (see the case descriptions that follow). Bowlby (1961) ascribed their responses to a “splitting of the ego” in which one part recognized that the mother was lost and another part did not recognize that the mother was lost (p. 486). He used the term *detachment* to explain this phenomenon. The contemporary term is *dissociative splitting*.

In the third volume of his book *Attachment and Loss*, Bowlby (1980) presented three cases involving children who were separated from their parents in the second year of life. These children demonstrated signs of dissociation that are relevant to the comparison model I describe later in this chapter. The following are brief synopses of each of these cases.

**Laura**

Laura, who was the subject of Robertson’s 1952 film, *A Two-Year-Old Goes to the Hospital*, was almost 2½ when she was admitted to the hospital for 8 days to correct an umbilical hernia. She had been given specific instructions from her mother not to cry, which was reinforced by the nurses who redirected Laura’s attention away from missing her mother (Bowlby, 1980). Most of the time, Laura was described as alone in her bed, looking sad, clutching her teddy bear, but not crying. However, her true feelings came out when she talked of an urgent wish to see a steamroller that was interspersed with “I want to see my Mummy!” While Laura’s mother visited her every other day, on the third and fourth visits, Laura looked blank
and made no attempt to interact with her mother until her mother was there for a while. Bowlby noted that each day Laura was experiencing increased helplessness and hopelessness with the lengthening separation from her mother.

Laura experienced another traumatic period of loss and separation 4 months later. She was sent to stay with her grandmother for 4 weeks while her mother had a new baby. Laura had no contact with either parent during this period. When Laura returned home, she banged on the door calling “Mummy, Mummy!” When her mother opened the door, Laura looked at her blankly and said, “But I want my Mummy.” For the next two days Laura seemed not to recognize her mother and, although not unfriendly, was completely detached (Bowlby, 1980, p. 409).

Kate
Kate, a 2½-year-old girl, was fostered by a couple for 27 days (Bowlby, 1980). Prior to placement, Kate’s parenting was described as rigid with a father who disciplined in quiet but threatening tones, and a mother who was softer but had high expectations of her daughter. Kate’s parents insisted that she be a good girl and not cry when placed in a foster home. Bowlby also surmised that her parents might have threatened not to love her if she did not listen. No details regarding what initiated her placement were provided, but generally children are placed in foster homes due to maltreatment. During Kate’s second week of placement, she expressed fear of getting lost, was clingy, and cried more easily. Bowlby noted that she “. . . at times seemed preoccupied and dreamy. On one such occasion, she murmured, ‘What is Kate looking for?’ a remark that seemed to indicate that she was temporarily losing track of her identity of the person for whom she was yearning and searching” (p. 395).

Bowlby surmised that Kate, who was inhibited from expression, feared that she might get lost and that her parents might not want her back if she was naughty—creating extreme fear in a 2½-year-old. I agree with Bowlby’s impression that she feared that she might get lost, but it also seems apparent to me that she felt lost from herself! Dreamy behavior and referring to the self in the third person can be indicators of fragmentation and dissociation. Kate’s referral to herself in the third person may have been due to a self-state that was unaware of Kate’s longing for her mother along with her feelings of loss and grief. Because Kate was highly inhibited from expressing her distraught feelings for fear of retaliation, she had no recourse but to segment them off. She may have already
been vulnerable to dissociation due to being raised by parents who took a harsh and punitive approach toward parenting. If she also suffered other forms of maltreatment, this would have made her even more vulnerable to dissociation.

**Owen**

Bowlby (1980) and his colleagues (Heinicke & Westheimer, 1965) studied Owen, who had just turned 2 when he was placed in a residential nursery after his mother was hospitalized. His mother came from an unstable home and had an unhappy childhood. She grew up feeling inadequate and insecure. Owen’s mother reported that he cried incessantly as a baby, at one point described him as a “little menace,” and threatened to pack up the children and send them to an institution. Owen spent almost 12 weeks in the residential nursery while his mother recuperated from surgery. Although his mother returned from the hospital after 5 weeks, she never visited him. Owen’s father, on the other hand, visited him regularly.

When Owen was first placed in residential care, he cried a lot (Bowlby, 1980). During the second week of his placement, Owen cried less and appeared emotionally detached. He would not say a single word to his father when he visited him. After his father left, Owen sobbed quietly for a few moments and then sat staring. In the succeeding weeks, Owen’s dissociative responses worsened to the point that he seemed to not recognize his father when he visited. Regarding his attachment to his mother, there was evidence that Owen was thinking of her. According to Bowlby, at times, he would quietly utter “Mummy” and call for her when he thought he heard her voice down the corridor.

Finally, Owen’s father took him home. Bowlby (1980) reported, “When his mother greeted him with ‘Hello, Owen’ he again appeared not to hear; instead he remained silent and expressionless on his father’s knee . . .” When his elder sister came bursting into the room to greet him, he turned away from her. She remarked, “It’s not Owen’s face. It is a different face.” Over several months, Owen was able to slowly reconnect to his mother and ask for comfort but was extremely obstinate and many battles ensued.

**Traumatic Grief in Children**

Bowlby favorably quoted Engle (1961), who stated, “Loss of a loved person is as traumatic psychologically as being severely wounded or burned is physiologically” (as cited by Bowlby, 1980, p. 42). Bowlby found this
quote applicable to the young children he studied who experienced sudden separation from their parents. An example of the debilitating impact of maternal separation on infants can be found in a grim and profoundly disturbing black and white silent film from the early 1950s called Psychogenic Disease in Infancy (Spitz, 1952). After 3 months of maternal separation, infants were shown displaying developmental regression and somatic rigidity. After 5 months, infants were lethargic, immobile, and arrested in weight and growth, with vacuous faces and bizarre finger movements. They were unable to sit, stand, walk, or talk. One infant continuously rocked on his back, which reminded me of Rudy (described later in this book) who was in an orphanage from birth until he was adopted at 18 months of age. At age 6, Rudy still compulsively rocked on his elbows and knees.

This separation or loss of a parent can lead to traumatic grief, which Bowlby termed pathological mourning. According to Bowlby (1961),

The main characteristics of pathological mourning is nothing less than an inability to express overtly these urges to recover and scold the lost object, with all the yearning for and anger with the deserting object that they entail. Instead of its overt expression, which though stormy and fruitless leads on to a healthy outcome, the urges to recover and reproach with all their ambivalence of feeling have become split off and repressed. Thenceforward, they have continued as active systems within the personality but, unable to find overt and direct expression, have come to influence feeling and behavior in strange and distorted ways; hence many forms of character disturbance and neurotic illness. (p. 485, italics added)

Bowlby (1961, p. 485) recognized that traumatic grief can become segregated within the personality and then influence the child’s behavior and feelings in “strange and distorted ways.” Robertson and Bowlby (1952) noted that during a prolonged separation, attachment behavior toward the mother can suddenly vanish, with the child treating his mother as if she were a stranger, and then the attachment behavior can suddenly reappear with the child clinging to his mother with fear and anger that he may lose her again. They termed the absence of attachment behavior as detachment. According to Bowlby (1982a), detached children did not seek comfort when hurt. Bowlby explained,
The signals that would ordinarily activate attachment behavior are failing to do so. This suggests that, in some way and for some reason, these signals are failing to reach the behavioral system responsible for attachment behavior, that they are being blocked off and the behavioral system itself thereby immobilizes... the whole range of feeling and desire that normally accompanies it can thus be rendered incapable of being aroused. (p. 673)

Bowlby (1982a) contended that this detached behavior is derived from unconscious mental processes that selectively shut off specific information without the person being aware that it is happening. There is blocking off of the signals both internally and externally that would allow the child to love and be loved. Bowlby called this phenomenon “defensive exclusion” (p. 674).

In my view, this signal failure may be due to amnestic barriers or impermeable boundaries between different self-states that prevent the activation of the attachment behavior. Bowlby’s description is reminiscent of a toddler who formed a dissociated state that was not “born” from his mother and was not developed within the context of any attachment figure. The state was developed to help the child survive by not wanting his mother, because if he did then he would experience further loss and grief. Because these systems were created in the absence of any nurturing figure, the self-state did not know to seek comfort when hurt.

Bowlby’s Case Study of Geraldine: Undiagnosed DID
Although Bowlby (1980) focused most of his research on loss and mourning in preschoolers, he also analyzed loss and mourning in an older child, Geraldine, and found evidence of clear dissociative states. Although Bowlby did not have the advantage of current nosology of dissociation, he uses the term deactivation and the concept of “segregated systems” when describing two separate personalities in Geraldine, whose mother died of cancer when she was almost 8 years old (pp. 338–349).

Aside from losing her mother, Geraldine came from a chaotic home. Her mother was described as an extremely bright, difficult, demanding, domineering, and stubborn woman with a volatile and periodically uncontrolable temper. Geraldine’s father was an alcoholic, and there were often violent fights between her parents, resulting in several separations. At
one point, after Geraldine’s father was hospitalized with pneumonia, her mother packed their belongings and left without telling him.

Two years after her mother’s death, 10-year-old Geraldine was found wandering in a dazed state with severe amnesia. She did not know who she was or where she was. She had a severe headache and realized that her mother was not with her, and that she was on the wrong bus. She asked a stranger to take her to the hospital and her neurological exam was normal. However, Geraldine had no recall of her mother’s terminal illness and subsequent death, or of her other wandering episodes. After her amnesia, she lost all of her math ability. A year later, at almost 11 years old, Geraldine entered therapy. She presented in therapy with a calm, self-assured demeanor with a vocabulary beyond her years, but offered little about herself. She factually stated that she knew her mother was dead but could not remember her mother’s death and had no associated affect.

Geraldine’s demeanor would change dramatically during her therapist’s absences or during anniversaries of her mother’s death. When her therapist was away, Geraldine verbally attacked her father, blaming him for his neglect, something that she had never voiced earlier. Her father remarked that her behavior was so much like her mother’s that he thought his wife had returned from the grave. At other times, Geraldine was depressed, cried often, engaged in serious fights with peers, and blamed her therapist for leaving her. The anniversaries of her mother’s death seemed to open the door to Geraldine’s memory for what her life was like with her mother. She began to talk about her mother’s unavailability and neglect and described herself as lonely and having to care for herself when her mother was alive.

Later in therapy, Geraldine recovered her memory of the last days of her mother’s life and her mother’s funeral. Geraldine expressed intense grief. With the support of her therapist, Geraldine was slowly able to erode the amnestic barriers and began to allow herself to experience the previously disassociated feelings. Geraldine eloquently described what she called three phases of her life and recovery:

At first, I blotted out all feelings—things happened that were more than I could endure—I had to keep going. If I had really let things hit me, I wouldn’t be here. I’d be dead or in a mental hospital. I let myself feel nothing and my thoughts were all involved with fantasies, fairy tales, and science fiction. Then in the second phase, my
feelings took over and ruled me. I did things that were way out. And the third phase, now, is that my feelings are here. I feel them and I have control over them. One of my big assets is that I can experience things with genuine feelings. At times it hurts but the advantages, the happiness, far outweigh the pain. (Bowlby, 1980, p. 342)

Geraldine’s statement is very similar to statements that I have heard repeatedly from traumatized, dissociative children during their recovery.

Analysis of Geraldine’s Case
Bowlby (1980) recognized that Geraldine had developed two segregated systems of consciousness (self-states) after her mother’s death with separate memories, affect, and behaviors. The personality that developed after her mother’s death knew her mother was dead, but did not remember it and had no affect over her loss. This was a part that was created after Geraldine was at the breaking point with overwhelming grief. The other self-state, the grieving child who recalled her mother’s dying and death, was hidden and unconscious, but surfaced when she was triggered by her therapist’s vacations and on the anniversaries of her mother’s death. The intense grief and mourning that this part felt was too unbearable for her to manage at the moment of her mother’s death, thus necessitating the creation of the part of her that had no memory or attachment grief.

Geraldine’s exposure to interpersonal violence within the home prior to her mother’s death laid the foundation for using dissociative mechanisms, especially when witnessing her mother’s volatile temper and violent fights with her father and sister. Geraldine’s attachment with her mother would meet the criteria of disorganized attachment. Her mother was frightening in her unpredictable moods and behaviors. Geraldine survived by becoming nondemanding and unexpressive. She feared abandonment by her mother, who had previously taken the children and left her father without warning. Geraldine told her therapist, “How could I ever be mad at Momma—she was really the only security I had. You really have to side with the parent who looks after you” (Bowlby, 1980, p. 342). Even though the security was tenuous at best, it was all that she had.

As Geraldine was connecting with her grief, she remarked to her therapist, “With Mamma, I was scared to death to step out of line. I saw with my own eyes how she attacked, in words, and actions, my Dad and sister and after all, I was just a little kid—very powerless” (Bowlby, 1980, p. 342). Geraldine had an intense fear of stepping out of line with her mother.
However, as with any child in such an environment, Geraldine was in a perennial dilemma. She feared her mother even though her mother was her only security. These are the very conditions that can cause a child to dissociate. Geraldine had no choice at such an early age but to segment off her feelings for risk of losing the fragile bond she had with her mother.

These cases highlight how parental separation, loss, and maltreatment can cause children to split off from expressing their feelings in order to survive. This is especially true in children who have an ambivalent or disorganized attachment with their parents prior to the separation. Although this fragmentation helps the child cope, it comes at a great expense to his or her psychological and physical well-being.

**Bowlby’s Internal Working Models and Development of Dissociated Self-States**

Bowlby (1973) defined what he called segregated states as “states of the mind” (p. 203). According to Bowlby (1982b), the child develops internal working models from caretakers and significant others. These models begin to develop within the first few years of life and become incorporated into the child’s identity. The development of these working models is an unconscious process based on children’s expectations about how the physical world operates, how their mother and other significant people may be expected to behave, and how all of them interact with each other. Children then make plans on how to respond to their parents (including attachment behavior) based on perceptions of how accessible, responsible, and acceptable they are to them (Bowlby, 1973).

Children can develop different and incompatible internal working models based on fear-provoking situations with parents who are frightening, neglectful, or abusive. Children abused by caregivers can develop two incompatible working models of the abuser: one who is the loving parent and the other who is the abuser. They can also develop incompatible models of their self—one as the victim and the other as the apparently normal child who attends to daily functions (van der Hart et al., 2006). These incompatible models may result in the development of distorted and biased perceptions in future relationships.

**Psychological Responses to Grief and Mourning**

Robertson and Bowlby (1952) originally recognized three phases that children experienced when separated from their mothers: (a) protest (related
to separation anxiety), (b) despair (related to grief and mourning), and (c) denial or detachment (related to segregated systems). Later, Bowlby (1960) studied the stages of grief and mourning that older adults experienced over the loss of their spouse or another loved one and noted a similarity with children’s responses to maternal loss and lengthy separation. Based on this new research, Bowlby (1960) revised his model into five stages of psychological responses to grief and mourning. These stages are: (1) thoughts and behaviors still directed toward the lost object; (2) hostility directed toward others; (3) appeals for help; (4) despair, withdrawal, regression, and disorganization; and (5) reorganization of behavior directed toward a new object. Bowlby recognized that the child’s intense and unresolved grief over the loss of a parent is the underlying dynamic in these stages.

**Star Theoretical Model Compared to Five Stages of Psychological Responses to Trauma in Dissociative Children**

I have found patterns similar to Bowlby’s (1960) five stages of psychological responses to grief and mourning in dissociative children who have also experienced interpersonal trauma such as physical, sexual, or emotional abuse, and witnessed domestic violence. Because they provide a useful framework, I have incorporated these psychological stages into the STM. My model also incorporates Bowlby’s concepts regarding attachment, internal working models, and segregated states. Bowlby recognized that segregated states could occur in response to various situations in which the child’s bond with the parent is disrupted, including rejection, maternal depression, the arrival of a new baby, separation from a parent, or other similar situations. I include maltreatment on this list in my model.

Loss and grief is inherent in all traumatic experiences, particularly in interpersonal trauma perpetrated by a caregiver or someone a child trusts. When a child is abused by a parent, in many ways the child has lost that parent, as the child can no longer trust the parent to keep him or her safe. Protesting does not bring the attachment figure back. The child is left with feeling fearful, helpless, depressed, and desperate. The child reverts to the most primitive, survival response—engaging the parasympathetic ANS (Porges, 2011) and dissociates. The child thus seeks to escape the trauma by splitting off the experience and associated emotions from conscious awareness into segregated systems. This is an unconscious,
instinctive survival mechanism that protects the child from unbearable loss and grief associated with the trauma.

In my comparison model, traumatic events can be dissociated across the domains of affect, cognition, behaviors, sensations, and relationships and, in severe cases, leads to the development of self-states. Self-states can range from fragments of the self with limited roles, behaviors, and affect, to more developed states that take executive control over the child’s body.

Not all maltreated children experience each of the five stages of psychological responses of grief and mourning, or experience them sequentially, or display segmented discrete states. Rather, the STM recognizes these as psychological responses to be considered when evaluating children who have been exposed to trauma. Furthermore, this comparison model can be a guide during assessment and treatment to alert the clinician to the child’s reactions to traumatic loss and mourning, and, consequently, the development of dissociative states to be coped with. I describe each of the stages to aid the clinician in understanding the underlying dynamics associated with the child’s self-states.

**Stage 1: Thought and Behavior Still Directed Toward the Lost Object**

In Bowlby’s (1960) stage 1, the child protests loudly in the hopes of being reunited with the parent. All thoughts and behavior are directed toward reunification with the parent. In my comparison model, when abused, the child experiences grief over the loss of the desired, idealized perception of the parent. The child blames himself or herself and feels unworthy of love, which can lead to feelings of depression. (A similar dynamic can occur even if the abuser is not a primary caretaker.) These unbearable feelings and contradictory perceptions of still desiring the love of the caregiver while fearing him or her are too difficult for the child to manage. In order to maintain the child’s attachment to the parent, the child has to segment off the abusive experience along with the feelings of abandonment, betrayal, rejection, and loss of safety. The child compensates by developing self-states representing the abuser and/or the unbearable affect associated with the abuse. By segmenting this information from the child’s awareness, the child is able to maintain attachment to the abusive parent and avoids the unbearable pain of parental abuse.

**Stage 2: Hostility Directed Toward Others**

In stage 2, Bowlby (1960) described children in residential care exhibiting hostility toward anyone who tried to nurture them. They would vacillate
between rejecting care and clinging to the nurses. This contradictory behavior is frequently found in dissociative children who can display loyalty to an abusive parent, while also being angry with them. The child faces a dilemma. He feels hostile toward his parent for abandoning him psychologically and/or physically and for being maltreated. However, he fears further rejection and retribution if he shows hostility. At the same time, he desperately wants to be loved and comforted. He thus has to dissociate his feelings of fear, anger, and hostility to protect himself from further rejection or harm. This hostility can become segmented into a self-state that exhibits aggression, anger, distrust, and suspicion of others. The hostile state hates feeling afraid because that feeling makes the child feel vulnerable. The fear then becomes segmented into a fearful state that feels impotent, dependent, and wanting to please others to avoid rejection and harm. The fearful state seeks out comfort and is loyal to the perpetrating parent for fear of rejection, whereas the hostile state despises the fearful state for its weakness. Consequently, when the different states are activated, the child can vacillate between closeness, hostility, and aggression.

These responses can become generalized toward all caregivers, including foster and adoptive parents who try to nurture the child. As a result, the child’s presentation can be very confusing. One moment the child may be showing intense fear toward his caregiver, and then suddenly the child may shift to seeking out comfort. When comfort is provided, the child may feel threatened and switch to the hostile self-state—hitting, kicking, and swearing at the caregiver. If it is too threatening for the child to express his hostility outwardly, he will turn it inwardly with self-harming behaviors such as head banging, cutting, burning, purging, or substance abuse.

The hostile self-state can appear whenever the child is unconsciously reminded of the grief caused by the traumatic relationship. This places further strain on a nonabusive caregiver who tries to comfort the child, as attempts to nurture the child may trigger extreme distrust in a hostile self-state. If these extreme shifts between desiring closeness and meeting it with hostility persist into adulthood, the individual may be diagnosed with having borderline personality disorder.

Stage 3: Appeals for Help
In Bowlby’s (1960) stage 3, the child’s appeals for help are unmet and the child becomes resigned to the fact that the absent parent is unavailable. When this reality sets in, the child feels much despair. He feels immobilized
with fear and distrust and is thus unable to reach outwardly for help, as this seems too dangerous and unpredictable. However, his overwhelming need for nurturing and comfort propels him to seek “internal” ways to satisfy this need. In my model, the child develops an internalized self-state—that is, a helper, an idealized parent, a comforter, or a hero figure—to rescue him. Reliance on an internal helper enables the child to feel safer, particularly when outside help has not been consistently available. I have frequently found helper states in children who resided in orphanages during their infancy and toddlerhood. Because they had no consistent caretaker, they sought refuge from within and created internal comforters/rescuers when they were hungry, cold, or lonely.

Stage 4: Despair, Withdrawal, Regression, and Disorganization
In stage 4, Bowlby (1960) found that toddlers who were separated from their mothers exhibited despair, withdrawal, regression, and disorganization. Bowlby stated, “...there is no experience to which a young child can be subjected more prone to elicit intense and violent hatred for the mother figure than that of separation” (p. 24). Bowlby noted research conducted by Heinicke (1956), who studied children between 16 and 26 months who were placed for short periods in a residential nursery with a limited number of nurses caring for them. Heinicke observed the children seeking their mothers throughout their stay with the majority of children exhibiting crying for their lost mothers, autoerotic activity, and intense aggression. In his research, Bowlby observed children vacillating between withdrawal, apathy, regression, mourning, and aggression.

In my comparison model, the chaotic, disorganized responses often found in traumatized children can be attributed to rapidly switching self-states that may contain different affects (e.g., depression, hostility, fear, anger), varied behaviors (e.g., detachment, aggression, seeking support), and erratic skill performance in areas such as schoolwork, sports, and self-care. The self-states may also present at different levels of maturity and express different preferences regarding food, clothing, and so forth. These children are often highly sensitized to subtle traumatic cues. Thus, these state changes can occur without warning, making these children appear highly dysregulated and disorganized.

The underlying feelings that the child is trying to cope with are unmanageable despair, shame, and grief over being betrayed and the concomitant loss of safety, trust, and care. There is often a younger self-state that displays regressive behavior that appears to be the original self or a
self-state that was created at the time of the trauma. I recall a 10-year-old girl who had been severely abused from infancy until she was age 8. She had a complex configuration of self-states that would rapidly switch in response to minor stresses. One moment she would be curled up in a fetal position sucking her thumb and in the next moment she would be standing up and shouting profanities at her adoptive mother. These mercurial self-states can wreak havoc on the child’s ability to form attachments. The disorganized child’s self-states are based on a conflicting need for closeness and fear of closeness.

Furthermore, because these self-states can be formed for particular survival tasks (e.g., such as going to school, comforting the child, defending against any perceived threat), they were not created within a contextual relationship with others. Therefore, these self-states did not develop an internal working model of what it means to relate to another person. They are purely operating in a survival task-oriented mode and thus often exhibit detachment or inconsideration toward caregivers. Because of these behaviors, the children often appear to have reactive attachment disorder (RAD), marked by inhibited, emotionally withdrawn behavior toward adult caregivers with limited positive affect, along with irritability, sadness, or fearfulness. Because of fluctuating states of affect and contradictory attachment behavior, these children can make contradictory statements in short succession, such as “My mom is always mean to me. . . . She is nice to me.”

Stage 5: Reorganization of Behavior Directed Toward a New Object
In the last stage, Bowlby (1960) indicated that reorganization takes place partly in connection with the image of the lost object and partly in connection with a new object or objects. This is the final phase of mourning in which the lost object returns or a new object—another person—is found to which the child can attach. Bowlby indicated that if the child can attach to one adult, the mourning ceases; however, if the child is exposed to numerous adults (via placements or numerous caretakers), the child can become self-centered and will have shallow relationships over his or her lifetime.

Stage 5 corresponds to the later phases of treatment in my model (trauma processing and integration) as described in Chapters 10 and 12. This stage involves grieving the traumatic losses and pain across all parts of the child.

Based on my clinical experience with children and adults, I have learned that self-states are initially formed to protect the original self (the
very young child) who experienced the early trauma. This young part of the child may be hidden. For recovery to occur, this hidden self (as well as other states) must be uncovered, helped to process the trauma, and allowed to grieve their losses. This usually occurs in the latter stage of treatment after considerable reframing of defensive self-states into collaborators and engaging their participation in processing the traumatic events. The key for recovery is to access self-states that have served to protect the child and working with these self-states to let go of their defenses so that grief work can occur. (A case that exemplifies this process is that of Martha described in Chapter 6.)

In a supporting, loving environment, the self-states who serve to protect the hidden, hurt young child—the original self—from the raw pain of traumatic losses will be able to let down their defenses and support the young child and other self-states to experience and master their pain and losses. Once the pain of the traumatic experiences and loss of attachment figures are processed, then trust in self and others can be established. This will open the door for the child to develop the capacity to form enduring attachments as an integrated individual. This process is described throughout this book.

Unless this last phase is completed, self-states can continue to disrupt the child’s ability to form meaningful relationship with parents, even when the child has a loving caregiver. Defensive self-states may attempt to sabotage the attachment process with current caregivers as well as with others. As a result, the child will continue to display vacillating and chaotic reactions toward caregivers and peers, and will have significant difficulty in managing relationships as an adult.

**Developmental Theory**

Erik Erikson is the father of developmental and ego psychology. I rely on Erikson’s developmental framework as the basis of my developmental theory, particularly because his main focus is the development of ego identity—the “conscious sense of self” that is developed through social interactions (Erikson, 1968). According to Erikson, ego identity is constantly changing due to interactions between the body (genetics), mind (psychological), and cultural influences. A person’s identity is shaped by human experiences and interpersonal interactions, in which new experiences are continually being assimilated, resulting in solidifying, modifying, or
disrupting earlier patterns of beliefs, affect, and behavior. Erikson’s theory provides a basis for understanding how identity formation is disrupted by trauma.

Erikson’s (1963) eight stages of psychosocial development encompass the life span of the individual. New experiences and information are obtained from daily interactions with others and impact the ability to be competent in each stage of psychosocial development. These stages parallel biological maturation and cognitive development. They are mastered within the context of significant relationships and therefore overlap with attachment and family theories.

Erikson’s psychosocial eight stages are: (1) basic trust versus basic mistrust in infancy, (2) autonomy versus shame and doubt in toddlerhood, (3) initiative versus guilt in early childhood, (4) industry versus inferiority in preadolescence and late childhood, (5) identity versus role confusion for the adolescent period, (6) intimacy and solidarity versus isolation in young adulthood, (7) generativity versus self-absorption in adulthood, and (8) integrity versus despair in old age. These stages are particularly helpful in understanding the enormous challenges that traumatized children face, as trauma disrupts the child’s development—particularly when it is incurred at the hands of a caregiver. Erikson’s framework is complementary to Bowlby’s attachment theory and together they form the essence of my approach to treating dissociative children.

Erikson (1963) outlined an order and timing for these psychosocial stages with the parents playing a major role in the child’s early stages of development. Each stage builds on the preceding stage and paves the way for accomplishing subsequent stages. An individual achieves a stage of development after dealing with a biological crisis. In order to move through each stage, the individual experiences tension and conflicts within the “relational context” that effect resolution and competency. Ideally, the crisis should be resolved in order for development in the next stage to proceed. By mastering each stage, a person develops ego strength. However, failure to master a stage can result in less ability to manage the next stage, thereby leading to an unhealthy personality and a diminished sense of self. According to Erikson, if a crisis at an earlier stage is not fully mastered, it will likely resurface later in life.

Table 1.1 shows the significant relationships that play a role in the individual’s success in mastering each stage along with favorable and unfavorable outcomes. Because early and chronic childhood trauma often thwarts the achievement of many of these stages, it is important to examine
<table>
<thead>
<tr>
<th>Stage (Age in Years)</th>
<th>Psychosocial Dialectic</th>
<th>Primary Activity</th>
<th>Significant Relationships</th>
<th>Favorable Outcome</th>
<th>Unfavorable Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1</td>
<td>Trust vs. mistrust</td>
<td>Consistent, stable care from parents</td>
<td>Main caregivers</td>
<td>Trust and optimism</td>
<td>Suspicion, withdrawal, and fear of future events</td>
</tr>
<tr>
<td>2–3</td>
<td>Autonomy vs. shame and doubt</td>
<td>Consistent, stable care from parents</td>
<td>Main caregivers</td>
<td>Sense of autonomy and self-esteem</td>
<td>Feelings of shame and self-doubt</td>
</tr>
<tr>
<td>4–5</td>
<td>Initiative vs. guilt</td>
<td>Environmental exploration</td>
<td>Family, social institutions</td>
<td>Self-direction and purpose</td>
<td>A sense of guilt, anxiety, and inhibition</td>
</tr>
<tr>
<td>6 to puberty</td>
<td>Industry vs. inferiority</td>
<td>Knowledge acquisition</td>
<td>Family, neighbors, peers, and school</td>
<td>Sense of competence and achievement</td>
<td>A sense of inferiority and inadequacy at doing things</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Identity vs. role confusion</td>
<td>Coherent vocation and personality</td>
<td>Peers, group affiliations</td>
<td>Integrated self-image</td>
<td>Confusion over who and what one really is</td>
</tr>
<tr>
<td>Early adulthood</td>
<td>Intimacy vs. isolation</td>
<td>Deep and lasting relationships</td>
<td>Friends, lovers, partners, and family</td>
<td>Ability to experience love and commitment</td>
<td>Inability to form affectionate relationships; self-absorption, isolation</td>
</tr>
<tr>
<td>Middle adulthood</td>
<td>Generativity vs. stagnation</td>
<td>Productive and creative engagement in society</td>
<td>Offspring, family</td>
<td>Concern for family, society, and future generations</td>
<td>Concern only for self—one’s own well-being and prosperity</td>
</tr>
<tr>
<td>Late adulthood</td>
<td>Ego integrity vs. despair</td>
<td>Life review and evaluation</td>
<td>Humankind and extended family</td>
<td>Sense of satisfaction; acceptance of death</td>
<td>Dissatisfaction with life; fear over death</td>
</tr>
</tbody>
</table>

Adapted from Erikson (1963).
the timing of children’s trauma and to explore how the trauma influenced their ability to master the stage they were in when the trauma occurred and how the trauma affected their subsequent development.

**Similarities Between Erikson’s and Bowlby’s Models**

Erikson’s developmental model is complementary to Bowlby’s model of attachment. Bowlby emphasized the first few years of life as having a profound impact on the identity formation of the child, whereas Bowlby (1980, 1982b) agreed with Erikson that the development of identity is a lifelong process that is primarily influenced by relationships. Pittman, Keiley, Kerpelman, and Vaughn (2011) provide an extensive comparison between Bowlby’s and Erikson’s models. In their seminal article, they noted that the importance of a secure attachment is recognized in Erikson’s psychosocial stages. Although attachment research has focused mainly on infancy and early childhood, and developmental theories have tended to emphasize identity issues in adolescence and young adulthood, both theories recognize that early relationships are extremely influential in an individual’s life. Healthy attachments provide individuals with the ability to successfully accomplish each phase and prepare them for managing the next phase.

**Comparing Erikson’s Model With the Star Theoretical Model**

Both Erikson’s theory and the STM are primarily concerned with the construction of identity and the relational influences impacting that process; however, the STM also emphasizes the impact that traumatic experiences can have in disrupting the child’s ability to develop a cohesive identity. The STM thus focuses more closely on how the fragmentation of identity can impair a child’s capacity to master developmental conflicts. The developmental portion of the STM holds that when a child is traumatized, the child can develop internal states with specific characteristics across multiple domains: behavioral, affective, relational, cognitive, spiritual/beliefs, and neurobiological (Figure 1.3).

The STM contends that each self-state can have divergent thoughts, feelings, relational capacity, and beliefs, along with neurobiological differences that can impair the child’s ability to effectively achieve developmental stages. To add complexity, certain self-states can be at different...
levels of development, further thwarting the child’s ability to form a cohesive identity. Therefore, when evaluating a traumatized child, in addition to recognizing the child’s current age-appropriate psychosocial stage, it is important to know the child’s psychosocial stage when the self-state was developed because that self-state can be stuck at that stage. This self-state can then interfere with the child’s ability to deal with current developmental crises. For example, a 12-year-old with early and chronic trauma can have a self-state stuck at the developmental level of a 3-year-old, if this is when the trauma first occurred. The presence of this self-state will then impair the child from performing at his or her appropriate age level. My model holds that for successful treatment, the 3-year-old self-state will need to be included in the treatment process so that the child will be able to process the traumatic event that caused the self-state’s creation and therefore master subsequent developmental stages. Then, the self-state can integrate within the child, forming a cohesive identity.

Family Systems Theory

*Feelings of worth can flourish only in an atmosphere where individual differences are appreciated, mistakes are tolerated, communication is open, and rules are flexible—the kind of atmosphere that is found in a nurturing family.*

—Virginia Satir (n.d.)
Satir’s profound words are what we all strive for in our personal and professional lives. We recognize that children’s feelings of self-worth are primary to their health, and that we, in both big and small ways, must communicate this message to them. I had the honor to learn about Satir in my undergraduate work and, to this day, I find her model to be solid and timeless. I, therefore, largely base the family systems portion of the STM on her theories and approaches.

It has long been established that family interactions play a significant role in the pathology of children, who are often the identified patients (Satir, 1983). Satir’s model of family therapy fits well with Bowlby’s and Erikson’s models, as each recognizes that children should not be defined by their symptoms. Satir viewed the identified client as carrying the distortions, pain, discomfort, and obstruction of growth that are found within the family system. Thus, Satir (1983) contended that the family needs to be treated as a unit when a child presents as the problematic client.

Satir postulated that a symptom is a report about the person wearing it, about the family, and about the rules in the family system. Accordingly, to understand the child’s symptoms, all family members at certain times need to participate in family therapy sessions, as a symptom in any family member is a sign of a dysfunctional family system. The therapist’s task is to understand the family rules that govern each person’s behavior. This requires a safe environment for exploring family rules, along with family members’ fears, and limiting behaviors.

Satir (1965) contended that each family member is unavoidably committed to the system of the family by the nature of the family member’s origin and dependency. Satir understood that the openness, flexibility, clarity, and appropriateness of the family’s rules will determine whether developmental and life cycle changes that children and parents face will be managed in a healthy manner. In an open family system, rules promote change openly, directly, appropriately, and clearly. Conversely, in a closed family system, distortions, denial, and maintaining the status quo are prominent. When confronted with change, a closed system will maintain past, ineffective ways of interaction, thus inhibiting effective management of the demands of relationship and life cycle changes. The resultant pathology is often exhibited in the identified patient, who is often a child. I have found that due to their innocence, young children are more likely to reveal the family’s dysfunctions and secrets than older family members. Once these are revealed, change can occur.
When working with families, we need to recognize that we are working with three generations: the parents’ history, the current family, and the future family that the children will create when they become adults. It can be very valuable to look at the chronology of the family (comparable to a psychosocial history of individuals) and create a genogram with notations on intergenerational histories of trauma, mental illness, substance abuse, legal problems, and so forth. It is also important to explore with each parent what patterns they bring into the current family structure so that we can help the parents become conscious of repetitive patterns that may hinder growth. With adoptive children, we often have to surmise the rules they learned from their biological (and possibly foster) families. Children often reveal the rules they have learned via their communication patterns and behaviors. Having an open discussion with children about what they have learned can help promote healthier communication patterns.

Communication encompasses verbal as well as nonverbal behavior. The therapeutic aim is to close the gap between inference and observation and to document the relationship between patterns of communication and symptomatic behavior. The therapist’s role is to help family members clearly communicate their needs, wishes, and expectations while being on the lookout for contradictory messages.

Satir (1983, pp. 124–125) outlined three therapeutic beliefs about human nature: (a) every individual is geared to survival, growth, and obtaining closeness with others, no matter how distorted these may look; (b) what society calls sick, crazy, stupid, or bad behavior is really the person’s signal of distress and call for help; and (c) human beings are limited only by the extent of their knowledge, their ways of understanding themselves, and their ability to relate with others. Satir adhered to a growth model that is based on the notion that people change through interactions with other people and through an exploration of their inner life by exploring their own thoughts, intentions, and perceptions of others. The therapist’s role is to be the leader of the process but not the leader of people. Satir also recognized the importance of therapists exploring their own inner life, while exploring the life of the family. Satir’s guiding principles provide a foundation for our work with traumatized children and their families.
SUMMARY

The Star Theoretical Model (STM), comprising five theories—attachment, neurobiology, child development, family systems, and dissociative—is an integrative, comprehensive model that critically analyzes each of these theories and their corresponding relationships to understand the formation of dissociation and to conceptualize pathways toward treating the fractured child. This model can assist in formulating an accurate diagnosis and effective treatment course for children and adolescents with dissociation as demonstrated throughout this book. The underlying premise is that dissociation is an automatic, unconscious defense mechanism (based particularly on the neurobiology of trauma) that helps the child to survive unmitigated fear, helplessness, despair, shame, and grief over immense relational betrayal and other forms of trauma in which the child fears annihilation. The child’s mind segments off horrifying experiences in order to survive. Attachment theory is intentionally placed at the top of the star figure of STM to emphasize the paramount importance of being astute to the deleterious impact of traumatic experiences on the child’s ability to attach with caregivers and others and also to recognize that healing takes place in a safe, secure environment of compassionate and committed caregivers. Throughout this book, specialized techniques aimed at repairing attachment disturbances, stabilizing the dissociative child, processing traumatic experiences, and finally integrating the child’s mind are described with numerous rich clinical cases. In particular, the reader will learn about the progression of therapy in four cases—Rudy, Briana, Cathy, and Lisa—as their dissociative barriers are removed. The ultimate goal is for the dissociative youth to resolve past traumatic experiences and to become an integrated, cohesive individual who has the capacity to develop healthy attachments and to become a fulfilled and productive member of society.

NOTES

1. Available at www.isst-d.org/?contentID=76
2. Earlier research and clinical cases used DMS-IV (DDNOS) but with the current DSM-5, most of these cases would likely meet the criteria for OSDD.
3. All the names of the children in this book have been changed to protect the children’s identities. In addition, any identifying details have been altered.