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From the President

Atypical DID Adolescent Case

This is an atypical DID (Dissociative Identity Disorder) adolescent case noteworthy because of a singular, obscure precipitating traumatic event reported occurring in an apparently "normal family", the child's increased emotional vulnerability to dissociate because of insecure maternal attachment, the rapidity of recovery due to the parents' support coupled with the early detection of and successful intervention with dissociative states. During this time-limited evaluation, the use of dissociative checklists expedited the evaluation process, which was filled out prior to the evaluation. They included the Adolescent-Multidimensional Inventory of Dissociation (A-MID) (Dell, 2004), the Adolescent Dissociative Experience Scale (ADES), (Armstrong, et al, 1997), and the Trauma Symptom Checklist, (TSC) (Briere, 1996).

Sarah Doe, 17 years old, was referred to me by her mother for an evaluation due to the presenting diagnoses of dissociative amnesia and Eating Disorder NOS, provided by her treating psychiatrist and clinical psychologist. Because her intact family resided in another state I did an extended evaluation and intervention techniques lasting nine hours over a day and half. Both of her parents and her only sibling, a college-age sister, participated in the evaluation.

When evaluating Sarah, I utilized the Quadra-Theoretical Model for Assessing and Treating Dissociation in Children (Waters, 1996), which is a diamond shaped model integrating four theories: attachment (at the apex of the diamond because of its significance), family, developmental and dissociative.

The first day of the evaluation, I initially met with the entire family to gather significant childhood developmental history, some family history, their description of Sarah's presenting symptoms and to observe family interactions. I then met with Sarah individually for most of the day, concluding with another family meeting to discuss current findings, with Sarah's approval. The second day began with a meeting with Sarah and her parents to review the prior evening. I resumed meeting individually with Sarah, and then concluded the evaluation with the entire family summarizing my impressions and recommendations. This was followed by a short individual session with Sarah's mother to recommend individual therapy.

Sarah was a pleasant, attractive, 17 year old young woman of average height, weighing 100 lbs and in the eleventh grade. Initially, she presented with a flat affect and significant confusion about her life. With occasional brief moments of spotty memory, overall, Sarah described complete amnesia for her present daily life, including parents, home and academic environments, year long boyfriend, and peers. She had some recognition of her sister, who was three years older. She did not recognize her therapist or recall their weekly sessions. An exception to her amnesia was Sarah's recollection of childhood friends as early as three years old until around seven years old, and her deceased paternal grandmother, with whom she had been very close.

During this time-limited evaluation, the use of dissociative checklists expedited the evaluation process

The onset of her dissociative amnesia occurred after she had received outpatient treatment for a year and was recently discharged from an inpatient

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treatment program for an eating disorder. Shortly after her inpatient release and after celebrating a school sporting banquet with her family and sisters, she began to faint repeatedly and was taken to the local hospital emergency room with complete amnesia. While in the ER, Sarah experienced severe pain in her ankle and could barely walk. Numerous exams and X-rays found no organic cause, but she limped for several weeks with prologue pain.

Regarding Sarah's history, she came from a middle class family with parents who were involved in her activities. She described herself as a daddy's girl, a tom boy, compliant, distant from her mother, and close with her accomplished sister whom she emulated. Since Sarah's amnesia, her mother has been emotionally attentive and their relationship has consequently strengthened. Throughout her high school years, Sarah was a class leader, high achiever, popular, and involved in many extra-curricular activities. She described herself as a pleaser,

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and unable to refuse participation in any civic program. Sarah would appease her friends at any cost to avoid arguments, and apologize even when she wasn't culpable. She would "bottle up" any negative affect. Sarah denied any form of child maltreatment or abuse and indicated that her parents had a good marriage, void of domestic violence and thus presenting a clinical puzzle about what triggered such amnesia and suspected splitting of consciousness. Regarding any losses, Sarah's paternal grandmother had died four years earlier. Her death was very difficult for the entire family, including Sarah's mother, Patricia, who viewed her mother-in-law more of a mother to her than her own mother who had a lengthy history of psychiatric hospitalizations, beginning at Patricia's own birth. I suspected that Patricia's own unresolved maternal attachment issues contributed to the distant relationship with Sarah.

Given how debilitating Sarah's life had become in the last several months, i.e. barely able to function in school, an accurate assessment and therapeutic intervention to alleviate Sarah's amnesia was paramount. As I began to educate about and to explore with Sarah her severe amnesia, she was articulate, open and motivated to understand herself and to be understood, thus forming an immediate rapport with me. She described internal auditory hallucinations of a "little girl," a "critical part," and a "control part." She displayed significant insight about her internal states and with careful questioning the dynamics of her splitting was unveiled. The seven year old "little girl" was the only one who had taken executive control over Sarah, while the other two self states remained internal but driving Sarah's feelings, thoughts and behaviors. Although a variety of trauma related questions were asked, Sarah denied any traumatic event during the first day of the evaluation which might account for such fragmentation when she was seven years old. Nevertheless, a clear description emerged regarding the functions of her self states as she described in detail being plagued by the internal voices', conflicting, contradictory messages.

Sarah had been highly driven with an enduring desire to please and to be "perfect" due to fear of angering anyone. She felt a commitment to fix everything, whether it was realistic or feasible, and emulated her older sister's achievements and abilities. Consequently she "stuffed" her feelings to meet these expectations. She was developmentally reaching a critical age as a 17 year old in which individuation and separation are further decisive developmental milestones to prepare for adulthood. However, as Sarah faced this developmental crisis, the emerging needs of the hidden "little girl" began to surface until she took full control of Sarah. The "little girl" wanted to play, relax and have fun, which had become an anomaly in Sarah's life, due to the persistent "Critical One," who would tell her to do more and to do it perfectly, join every civic group available, get straight "A's" etc. In order to resolve this intense conflict, the "Control Part" was created to essentially take control of the situation and protect the "Little Girl's" wishes. The main mechanism that the "Control Part" used was to take away Sarah's memory, which allowed the "Little Girl" to emerge to meet her desires to play and have fun. In addition, the internal presence of the "Little Girl" played a central role in Sarah's year long anorexia because Sarah kept seeing herself as needing to be little, through the eyes of the hidden "Little Girl." So she starved herself. The triggering event which prompted the child state to take executive control over Sarah occurred after the sports banquet when Sarah ate with trepidation and recreated the irresolvable struggle of the Critical Part telling her to eat, while simultaneously fearing "getting bigger," and seeing herself as little through the influence of the "Little Girl." The "Control One" decided to resolve this dilemma to protect the interest of the child state by removing Sarah's memory and power.

Through a dissociative treatment framework combining psychodynamic and cognitive approaches, immediate extensive cognitive reprocessing, reframing, and cooperation occurred between Sarah and her self states. A contract was established in which the "Control One" agreed to give back Sarah's memory if Sarah consented to relax more and have fun, which would meet the child state's need. Sarah quickly accepted that growing up doesn't mean that one can't have fun and that to retain the child-like qualities of spontaneity and playfulness are crucial to a healthy adult lifestyle. The "Critical Part" agreed to be renamed "Advisor" and accepted that it is impossible to be perfect and to please everyone. "Advisor" was encouraged to relax and to help Sarah set realistic expectations and limits and to

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encourage assertiveness.

The second morning of the evaluation, there was a marked improvement in Sarah's affect, memory, appearance, and overall outlook. Sarah remembered the entire first day of the evaluation, and her parents were delighted that Sarah had joked with them and recalled spontaneously information the previous evening.

The precipitating event that caused Sarah's dissociation was a mystery until I queried her further, suspecting that it pertained to her fear of expressing anger. Although she had previously denied any parental domestic violence, I reframed the question asking, "Was there any arguing between your parents or anyone else that had scared you or upset you?" She immediately reported a continuous vivid memory at seven years old witnessing an altercation between her parents when they returned home from a party, screaming at each other. Her father hit the wall with his fist and then left, leaving her mother crying. Since she was daddy's girl and not close to her mother, Sarah immediately experienced loss and abandonment, even though he returned the next day. Her parents never spoke of this incident, nor was Sarah able to receive comfort and reassurance to overcome her lingering fear of losing her dad, who was a powerful figure in her life. Even though this was an isolated incident, it shattered her security and contradicted her belief that she had a perfect family. This pivotal traumatic incident appears to have prompted her to dissociate and to drive her to perfectionism to avoid reexperiencing loss and abandonment. (Although with further assessment, it is possible that Sarah may have delayed recall of additional trauma.)

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In exploring Sarah's painful ankle and persistent limping, without any organic cause, when she was taken to the ER at the time of her full blown amnesia, I queried her about any injuries. She smiled, realizing the connection to an incident when she was seven years old when she had fallen from a tree, was taken to the ER, and diagnosed with a badly sprained ankle causing her to limp for several weeks. When the child dissociative state emerged and once again was taken to the ER, this triggered the painful memory of her sprained ankle. Sarah was educated about somatoform dissociation (Nijenhuis, 1999).

Given the speed of our evaluation and Sarah's dissociative states' willingness to cooperate and integrate, I did a fusion exercise through hypnotic suggestion to age progress the child state to Sarah's age and then the three dissociative states fused with Sarah. I made two audio tapes with Sarah on visualizing an internal safe place when she feels overwhelmed and a sensory psychotherapy exercise modeled after Grove and Panzier (1991) to help her resolve negative bodily sensations related to her eating disorder. She was encouraged to listen to them when she returned to her community for follow-up treatment.

Regarding the ratings on the checklists, Sarah presented on the A-MID with atypical dissociation, rating high on symptoms of amnesia, reported child and angry alters, and met the criteria of Dissociative Identity Disorder (DID) without Posttraumatic Stress Disorder and with low negative affect. Dell evaluation suspected that Sarah "lost" her host personality as a result of something unknown (her lack of reporting a traumatic event.) The A-MID provided accurate and pertinent details, which matched my clinical impressions. Sarah scored a 4.06 on the A-DES, which met the criteria for a Dissociative Identity Disorder, which I concurred. However, on the TSC, Sarah scored in the high range on the under-response scale, thus denying behaviors, thoughts, or feelings that most others would report at some level, and scored below clinical symptomatolgy on all of the clinical scales, including dissociation. It is difficult to ascertain her underreporting but it may pertain to a dissociative state's influence when filling out this checklist.

At the conclusion of the evaluation, Sarah and I informed her family about the cause of her splitting, and the subsequent integration of dissociative states. We made an agreement for Sarah and her mother to engage in activities to enhance a healthy attachment and a follow-up plan. Parents understood that since they had aged and their house was completely remodeled, the child state did not recognize them or her home.

I then met privately with mother to encourage her to seek individual therapy to work on her unresolved attachment issues with her mother, who was unable to adequately parent her due to lengthy severe mental illness. It was difficult to ascertain at this evaluation what mother's own history of attachment problems was. One can surmise that she may meet the criteria for having Disorganized Attachment. There has been much in the literature about the relationship between disorganized attachment and dissociation (Liotti, 1999; Lyons, 2003; Ogawa,et al, 1997). Mother's responses toward Sarah, particularly when she was younger, which may have been frightening, confusing, contradictory or dissociative, could be indicative of a second generation of disorganized attachment contributing to Sarah's own dissociation, This phenomena is described in Schuengel, et al. (1999) article.

Due to a lack of a specialist in dissociation in Sarah's community, she saw a generalist, who primarily worked with her on her eating disorder but unfortunately did not contact me for consultation. However, I did periodic follow-up calls with Sarah and her mother. After three months, Sarah still maintained her

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memory and integration, and was eating properly. At a nine month phone follow-up, Sarah's condition had deteriorated. She had gained 40 lbs. (partly due to a prescribed anti-psychotic medication, Zyprexa, known to cause significant weight gain), had recurring voices, and depression which was prompted by the unexpected, traumatic breakup with her boyfriend of two years, who had been extremely supportive during her amnesia. This triggered recurring loss and abandonment issues, and splitting again of the Critical/Advisor Part and the Control Part. However, the age-progressed, child part remained integrated. Sarah resumed self-degradation and self blame even though no specific event precipitated the breakup. She experienced only a few, five-minute incidents of amnesia and disorientation at school when she became angry. She reported not feeling close to her therapist who did not question her about any dissociative symptoms. Sarah wanted to tell her therapist about the recurring voices and call me for help, but she felt "stupid."

Parents immediately agreed to return Sarah to see me for follow-up intervention. I saw her for three hours. Sarah once again reprocessed erroneous beliefs about her culpability in the breakup, loss and abandonment feelings, perfectionism, and fear of growing up connected with some enmeshment with her mother. Her self states agreed to integrate. Sarah recognized how she was literally stuffing her feelings with over eating. Importance of locating either a therapist specializing in dissociation within driving distance or a commitment from her treating therapist to collaborate with me was stressed. Phone consultations and a two month follow-up session were arranged with me.

This case highlights critical factors in treating adolescents. First of all, when a child is in a safe environment with parents who are overall attentive and caring, regardless of some family history of pathology, children are more likely to benefit from intensive intervention. The early discovery and management of fluid dissociative states in children can prevent them from solidifying and can make rapid integration more feasible, thus preventing adult years of dysfunction. A positive transference with the therapist is critical for facilitating the recovery process. Exploration of impaired parent-child attachment relationships as a "precursor" or proclivity to dissociate should be analyzed, predominantly when there is fear of loss and abandonment coupled with witnessing domestic violence, or experiencing other forms of trauma, particularly given current research showing the relationship between dissociation and Disorganize Attachment. When the child does not receive comfort, a singular and/or obscure traumatic incident should be explored as to the impact on the child's coping mechanism. Traumatic incidents may not always be reported initially by typical abuse related questions, which means astute, subtle questioning may be required to elicit important information about trauma. Additionally, the treatment process should include ongoing assessment for possible further traumatic disclosures. A developmental crisis may spur the child to find escape through dissociation, if other conditions exist. A family history of mental illness may create some physiological vulnerability for a traumatized child to dissociate. The use of dissociative checklists can be a valuable adjunct to the evaluation interview. Finally, consultation regarding evaluation and follow-up treatment with a skilled clinician in dissociation is paramount for the child to maintain growth, integration, and appropriate medication.

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