Despite the clear and established link between dissociative psychopathology and early childhood trauma, dissociative symptoms often are overlooked in the diagnosis and, more important, treatment of children exposed to potentially traumatic events. A substantial body of evidence supports the idea that dissociation is central to the trauma response and to all trauma-related psychopathology, and that trauma-related disorders may be best understood as falling on a continuum that begins with peritraumatic dissociation and acute stress disorder (ASD) and ends with dissociative identity disorder (DID) (Figure 1, see page 686).

As summarized by Nijenhuis, van der Hart, and Steele, the theory of trauma-related structural dissociation of the personality posits that, when a person is traumatized, the traumatic event is not integrated into the memory in the usual way, and aspects of the personality that are associated with the trauma are cut off.
Figure 1. Continuum of pathological outcomes following exposure to potentially traumatic events.

The study of dissociation, from Janet in the 19th century to Nijenhuis in the 21st, has, not surprisingly, focused on the most extreme and complex end of this continuum, as patients at this end of the spectrum tend to exhibit the most dramatic, bizarre, and perplexing behaviors.

despite numerous contacts with mental healthcare providers. Attention to dissociative processes and symptoms was crucial to the diagnosis and successful treatment of this child.

PATIENT HISTORY

When Sam was 3 years old, a pot of boiling water spilled on him accidentally, resulting in scald burns to 15% of his total body surface area (TBSA), from his chin, down the left side of his body, to his belly button. Sam was hospitalized for 10 days. His medical recovery was unremarkable and Sam was not disfigured; when clothed, only one small scar under his chin was visible after his burns healed.

As is often the case for burn patients, Sam did not receive any psychological or psychiatric services as part of his burn care. Sam was referred to me 4½ years after the burn took place, by the social worker in the burn center where he had been hospitalized. Sam’s mother, Ms. C, had contacted the social worker due to her desperation and frustration over...
as well as her response to the repeated dismissals of her concerns when she tried to convince people that Sam’s difficulties were largely related to his experience of being burned. Ms. C explained that she had sought out a variety of services for Sam in the years since the burn and that nothing seemed to help. She reported that, before the burn, Sam had been a happy, very smart boy, who was developing normally, was toilet trained, and was beginning to learn to read. After he was burned, Sam’s personality changed completely; he lost previously acquired developmental skills, became timid, and stopped eating.

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Ms. C reported that none of the services Sam had received had addressed his experience of being burned and that none of the professionals who worked with Sam had ever even discussed the burn with her or Sam, despite her belief that many of Sam’s difficulties were related to it. After talking with Ms. C, I told her that it was possible that some of Sam’s problems were indeed related to his experience of being burned, and I agreed to see Sam for trauma-focused assessment.

When I first met Sam and his mother, I began by explaining to Sam that I had worked with many children who had experienced burns, and that being burned didn’t just hurt people’s bodies, but also hurt them inside, “in their feelings.” I explained that, just like his body had healed after he was burned, the “inside” hurts also needed to heal, and it was my job to help with this. I suggested to Sam and his mother that, once this healing took place, internal resources and energy now devoted to the trauma would become available for the tasks of everyday life.

I told Sam and his mother that my purpose in conducting a trauma-focused assessment was to try to understand how the experience of being burned had affected him, how he was coping with its effects at present, and whether the kind of treatment I could provide might be helpful to him. Sam told me that his burn did not bother him because he couldn’t remember it and that nobody, including me, could help him learn to read.

**INITIAL ASSESSMENT**

At this first assessment session, Sam exhibited extreme separation anxiety, appearing visibly terrified at the thought of his mother leaving the room. He had a...
Despite his anxiety and activity level, Sam was able to complete several self-report measures during this session while his mother completed several parent-report measures. Based on his own report, Sam clearly met the diagnostic criteria for PTSD, although he did not report experiencing symptoms that are usually hallmarks of the disorder: intrusive recollections or trauma-related nightmares. He endorsed only one reexperiencing symptom — intense psychological distress at reminders of the traumatic event — and four avoidance symptoms. Based on Sam’s report and those of his mother and teacher, he was experiencing all of the physiological arousal symptoms that comprise PTSD Criterion D. Sam also endorsed numerous symptoms of attention-deficit/hyperactivity disorder, all of which were likely due to his high levels of arousal and dissociation. He clearly met the diagnostic criteria for a separation anxiety disorder. He did not report clinical levels of symptoms of any other disorder.

Ms. C’s responses to the Child Behavior Checklist (CBCL)17 were consistent with Sam’s reports and clinical presentation, placing him in the normal range on the “delinquent” and “aggressive” behavior scales and at the 99th percentile for internalizing, “thought problems,” and “attention problems.” One of the most striking parts of the assessment was the consistency of Sam’s report and Ms. C’s report regarding dissociative symptoms (Sidebar, see page 688). It is unusual for parents to be able to report pathological dissociation in their children accurately, as these symptoms are highly subjective and internal and are not easily observed by others. Both Sam and his mother endorsed numerous dissociative symptoms, placing him well into the clinical range on both the Children’s Dissociative Experiences Scale (CDES)18 and the Child Dissociative Checklist (CDC).19

While he did not meet the diagnostic criteria for a DSM-IV dissociative disorder, dissociative symptoms were clearly central to Sam’s problems. Because Sam’s PTSD was not obvious, particularly to people who were not aware of his burn history, and because his symptoms were primarily of an internalizing nature, people tended to minimize or overlook his level of distress and to attribute his social and academic struggles to situational factors, family factors, or a lack of effort. At the completion of the assessment, I diagnosed Sam with PTSD with related dissociative symptoms and a separation anxiety disorder and recommended burn-related trauma-focused psychotherapy. After hearing my feedback and recommendations, Sam told me that he didn’t think about getting burned so it didn’t bother him. Due to scheduling conflicts, there was a 3-week hiatus before treatment could begin.

**THERAPEUTIC PROCESS**

When Sam and his mother returned for the first therapy session, two things became clear immediately. The first was that Sam’s dissociation of his burn experience had been highly adaptive; the second was that I had underestimated the level of his dissociative psychopathology and the degree to which his personality and daily functioning had been shaped by it. Sam and Ms. C both reported that, since our last meeting, he had been “bouncing off the walls” (Figure 2). Additionally, he had had several incidents of enuresis and encopresis, and Ms. C reported that Sam was “‘not listening,’” that she had to repeat things many times and literally “get in his face” to get his attention. In the 3 weeks since I had seen him, Sam’s behavior had changed from that of an anxious, “spaced out” 7-year-old (his apparently normal self) to that of a typical 3-year-old (his emotional self).

I interpreted the changes in Sam’s functioning as a direct response to the assessment that we had just completed. Although the assessment did not require Sam to talk about the details of the burn, it had forced him to think and talk about things that he had not thought or talked about for 4½ years. During those years,
Sam’s development and personality had been structured around cutting off trauma-related memories, thoughts, and feelings and keeping them inaccessible to consciousness and to his day-to-day “apparently normal” self. By bringing the traumatic event back into consciousness, we had opened up the floodgates for all of Sam’s trauma-related feelings and behaviors, and they had come rushing back.

I interpreted and normalized what had happened during the 3 weeks and explained to Sam that, when all of the trauma-related material was activated, his body and mind responded as if the trauma were occurring now. I told him, “Your body doesn’t know that you’re almost 8 years old. Sometimes it thinks you’re 3.” We talked about the fact that his brain could tell his body, “That’s crazy,” “I’m big,” “I’m not 3, I’m almost 8 years old,” and that the burn is in the past and he is safe now.

I also had Sam make a list of the people, places, and things that help him to feel safe and big, and had Sam pair these associations with a nightlight. Whenever his body started to act like he was 3, Sam was to press the nightlight and it would help him to remember that he was big and safe. At the end of this and subsequent sessions, Sam was prompted to say, “I’m safe. It’s over. It’s in the past.”

The day after this session, Ms. C called me, distraught. She reported that Sam had woken up in the middle of the night screaming and terrified and that it had taken a long time to soothe him. After he calmed down, Sam told her, “The bear is back.” After he was burned, Sam had a recurring nightmare involving a malevolent bear chasing after him; he had not had one of these dreams in over 2 years. I reassured Ms. C that it was not unusual for children to experience an increase in symptoms after beginning trauma-focused psychotherapy and that young children often have nightmares about monsters as opposed to replications of the trauma. After seeing Sam’s drawing of the moment when the scalding water spilled on him and a drawing of the bear that he had done at age 5 (Figure 3), I concluded that Sam had transformed the burning water into the bear and that the bear nightmares were, in fact, literal reenactments of the traumatic event.

Sam’s psychotherapy has had two major components occurring simultaneously: the integration of Sam’s memories of the trauma (often described as “exposure”), and the integration of dissociated aspects of Sam’s personality (often referred to as “parts work”). With children traumatized at a very early age, it is important to work with the child and primary caregiver together, if the caregiver has the capacity to do this.20 There are aspects of the traumatic event the child does not know and the caregiver does (often contextual details or things that happened when the child was not conscious), as well as aspects of the trauma that the caregiver does not know and the child does (often the child’s subjective experience and perceptions or events during which the caregiver was not present). By working with the caregiver and child together, it is often possible to put all of these pieces together.

Throughout Sam’s treatment, work on the story of the burn has involved both Sam and Ms. C telling the story of the burn with words and drawings. When they began telling the story, Sam (who, before this, had consistently denied remembering what happened) reported that his then 7-year-old sister, who was angry, had pushed him into his cousin who was holding the pot of water (Figure 4). This was information Ms. C had never heard before. During the first phase of telling the story, Sam experienced an increase in bear nightmares.
and separation anxiety. By modifying the nightlight intervention to stabilize Sam’s sleep, we were able to reduce his nightmares and anxiety.

As we continued to focus on integrating the details of his burn experience, he experienced a reduction in his “spaciness,” sleep disturbance, and difficulty concentrating. However, as Sam’s dissociative and hyperarousal symptoms decreased, new behaviors emerged. He began to express anger at home and was reported to be “angry and disrespectful” at school. Not surprisingly, Sam’s teachers had never observed such behavior before, as Sam had effectively dissociated the “angry part” of himself and previously had little conscious access to his anger.

In session, Sam expressed his anger and frustration over not being able to read. He resented the other children his age who were able to read without a struggle. We talked about how many children who have been hurt think that they are weak, or damaged, or not as good as other kids. I told Sam that, in fact, other children had had it a lot easier than he because they didn’t have to deal with being burned when they were 3. I introduced the metaphor of a race in which only one of the runners must carry a boulder: the other runners will get to the finish line first, but that does not mean the runner with the boulder is slow. In fact, the strongest runner is the one who must carry the boulder. He will get to the finish line later than the other runners, but his achievement will be much more impressive.

While we discussed this metaphor, Sam drew it (Figure 5), inserting cheering spectators on his own. This intervention, focusing on strength that Sam had previously viewed as weakness, acknowledged that his anger was appropriate and acceptable and made it possible for Sam to enter the next phase of his treatment — focusing on the most painful and previously least accessible aspects of his burn experience.

Telling the story of what happened after the water spilled on Sam involved talking about some of the most frightening moments of both his and his mother’s lives. It also meant including things that happened after both Sam and Ms. C had entered into intense dissociative states, which Ms. C reported that she felt sick while telling this part of the story. Sam reported that he did not feel anything and that he remembered his mother putting him in the front seat but didn’t remember anything else. After telling the story,
Sam said, “I’m safe, it’s over, it’s in the past,” without any prompting.

He then said he was hungry and asked his mother for a sandwich. When Ms. C responded that she had forgotten to bring sandwiches, Sam went into a regressed state, put his head down on the table, began sobbing, and did not respond to questions. I helped Sam to get up and go over to his mother, and I had him physically reenact the drive to the hospital by lying across his mother the way he had in the car. I instructed Ms. C to put her arm around him in the position they had been in during the drive, and say, “I’m sorry you got burned.” Sam responded by saying, “I don’t care about that.” I instructed Ms. C to apologize for forgetting the sandwiches. We then focused on the fact that Sam loves his mother and his mother loves him even when he feels mad or disappointed.

At the following week’s session, Sam had had only one bear nightmare, and Ms. C reported that he was more present and involved at school. On several occasions, he had told her to turn off the news when he overheard a disturbing story. She reported that “before he wouldn’t even have noticed” that the news was on, let alone taken in its content.

Sam was reluctant to draw about the next part of the story, so Ms. C drew it and Sam was instructed to color it (Figure 7). It was clear from this part of the story that Sam had taken care of his mother at the time of the burn by reassuring her, and that he continued to take care of her by trying to cut off those aspects of his experience and himself that were unbearable to her. This included any expression of sadness, fear, or anger.

Following this phase of treatment, many of Sam’s symptoms improved. He was attending and enjoying day camp and sleeping in his own bed some of the time. His separation anxiety had improved significantly, enabling him to attend a 1-week sleep away camp for burn survivors and, following his return, to go swimming by himself for the first time.

After his return from burn camp, Sam expressed a great deal of anger, mostly directed at his older sister. In the subsequent weeks, he had frequent nightmares, although he no longer dreamt of the bear. Although he had difficulty answering questions about his nightmares, Sam had no trouble drawing what he dreamt (Figure 8). Sam’s dreams were now about the different aspects of his personality that he had worked so hard to cut off but that had become accessible to his consciousness as he integrated his
burn experience: the divided parts of his “emotional personality,” associated with feeling anger, fear, and pain or vulnerability, and the “apparently normal personality” that tried unsuccessfully to escape from these parts.

In previous sessions, we had talked about the part represented by the wolf as the “mad or angry” part of Sam. I now reframed this as the part of Sam that could fight. We talked about the moment when the scalding water landed on Sam and he screamed. I explained that his immediate biological reaction to the pain before he shut down, which was to feel anger, was a natural, involuntary survival response and that humans respond to physical pain with anger because it prepares them to fight. We talked about the fact that he had shut down this part of himself when he was burned because it is impossible to fight scalding water and that the “fighting” part of him did not have to be scary or bad but rather was the part that had given him the strength to survive being burned, and even to try to take care of his mother in the midst of it. The fire in the dream represented the part of Sam that could be hurt, which he subsequently labeled as “gross and scary.” We talked about how feeling pain, while not fun, is part of being human and being alive, and that the part of him with the capacity to feel pain also gives him the capacity to feel love and joy.

The least complicated part of Sam’s treatment involved the integration of his traumatic experience, which led relatively quickly (within 10 sessions) to the resolution of his PTSD and separation anxiety disorder. The more complex and difficult part of his treatment, which is not yet complete, is focused on Sam accepting and integrating all the different parts of himself: the fighting part, the “scary and gross” part that feels, the 3-year-old Sam trying to have the fun he missed for 4½ years, and the 8-year-old Sam trying not to feel anything. Several weeks into this phase of his treatment, Sam came in and announced that he could read. As the dissociated aspects of both his traumatic experience and his personality become integrated, less energy is spent on keeping them out of awareness and divided, leading to healing and the availability of internal resources to manage present demands.

In one of his first therapy sessions Sam drew a picture that he labeled “Horizon” (see page 685). The horizon is the dividing line between the aspects of the world, the earth and sky. It is also the place where they are brought together, a point of integration and harmony. I have come to think of this drawing as a representation of Sam’s destination, a place where the previously divided aspects of his experience and personality come together to form something vibrant and beautiful.

REFERENCES