



The Effects of Dissociative Disorders on Children of Trauma Survivors

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One significant mental health issue concerns the recognition of trauma as the root cause of many psychiatric conditions. Until recently, Dissociative Disorders (DDs) have been considered to be rare and extraordinary phenomena. It is now understood that these conditions can be common effects of severe trauma in early childhood, most typically extreme, repeated physical, sexual, and/or emotional abuse. In 1994, with the publication of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders-IV*, the name and some of the diagnostic criteria for Multiple Personality Disorder (MPD) were changed to Dissociative Identity Disorder (DID), reflecting changes in professional understanding of the disorder. In 2013, with the publication of the DSM-5, even further changes were made to reflect new thinking in the science of traumatic stress. To make this article easier to read, I will use the acronym DID throughout; the points made, however, may apply to a variety of dissociative conditions.

Parenting is difficult under the best of circumstances, but parents who live with trauma disorders have particular challenges. Advocates who work with children of people with dissociative or other trauma disorders can be more effective if they appreciate the unique stressors faced by parents and children in these often troubled families. The intergenerational effects of dissociative trauma disorders is an area of study that is truly on "the cutting edge" for clinicians, researchers, and the legal and social service fields. Although several institutions are currently studying the effects on children of living with a dissociative parent, there is as yet very little data on the children themselves. For this reason, much of this article focuses on the parents, in the hope of shedding light on the dynamics within the families.

People who chronically dissociate often refer to the experience as "spacing out" or "trancing." Technically, dissociation is a mental process which "disconnects" a person's thoughts, memories, feelings, actions, or sense of identity. When a person is dissociating, certain information is not associated with other information as it normally would be. For example, during a traumatic experience, one's memory of the place and circumstances of the trauma may be dissociated from ongoing memory. This produces a temporary mental escape from the fear and pain of the trauma and, in some cases, a memory gap surrounding the

experience. Because this process can cause changes in memory, a person who frequently dissociates may find their sense of personal history and identity are affected.

Most clinicians believe that dissociation exists on a continuum of severity. This continuum reflects a wide range of experiences and/or symptoms. At one end are mild dissociative experiences common to most people, such as daydreaming, highway hypnosis, or “getting lost” in a book or movie, all of which involve “losing touch” with conscious awareness of one’s immediate surroundings. At the other extreme is complex, chronic dissociation, which may result in serious impairment or inability to function.

It is important to understand, however, especially in light of implications for parenting, that people with DID can hold highly responsible jobs and contribute to society in a variety of professional, artistic, and service-oriented ways. To family members, co-workers, and neighbors with whom they interact daily, they apparently function normally. An evaluation of a person’s ability to be a successful parent should be based on the circumstances of each particular case, and not on the fact that a person has been diagnosed with a dissociative disorder. People who have DID can be responsible, loving parents.

Dissociative disorders develop under fairly consistent circumstances. When faced with overwhelmingly traumatic situations from which there is no physical escape, a child may resort to “going away” in his or her head. This ability is typically used by children as an extremely effective defense against acute physical and emotional pain, or anxious anticipation of that pain. By this dissociative process, thoughts, feelings, memories, and perceptions of the traumatic experiences can be separated off psychologically, allowing the child to function as if the trauma had not occurred.

Dissociation is often referred to as a highly creative survival technique because it allows individuals enduring “hopeless” circumstances to preserve some areas of healthy functioning. Over time, however, for a child who has been repeatedly physically and sexually assaulted, defensive dissociation becomes reinforced and conditioned. Because the dissociative escape is so effective, children who are very practiced at it may automatically use it whenever they feel threatened or anxious—even if the anxiety-producing situation is not abusive. Often, even after the traumatic circumstances are long past, the left-over pattern of defensive dissociation remains. Chronic defensive dissociation may lead to serious dysfunction in work, family, social, and daily activities. Repeated dissociation may result in a series of separate entities, or mental states, which the trauma survivor may perceive as having identities of their own. These entities may become the internal “personality states” of a DID system. Changing between these states of consciousness is described as “switching.”

People with dissociative disorders may experience any of the following: depression, mood swings, suicidal tendencies, sleep disorders (insomnia, night terrors, and sleep walking), panic attacks and phobias (flashbacks, reactions to stimuli or “triggers”), alcohol and drug abuse, compulsions and rituals, psychotic-like symptoms (including auditory and visual hallucinations), and eating disorders. In addition, individuals with DID can experience headaches, amnesias,

time loss, trances, and “out of body experiences.” Some people with dissociative disorders have a tendency toward self-persecution, self-sabotage, and even violence (both self-inflicted and outwardly directed). Parents debilitated by trauma disorders share common family difficulties with other parents who have mental illnesses. These parents may be emotionally unavailable to their children, may neglect them, and may be unable to model responsible adult behavior. Often in such families, young children become “parentified,” taking on the nurturing parental role, caring for younger children and for the disabled parent, as well.

The vast majority (as many as 98 to 99%) of individuals who develop DID have documented histories of repetitive, overwhelming, and sometimes life-threatening trauma at a sensitive developmental stage of childhood (usually before the age of nine), and they may possess an inherited biological predisposition for dissociation. In our culture the most frequent precursor to DID is extreme physical, emotional, and sexual abuse in childhood, but survivors of other kinds of trauma in childhood (such as natural disasters, invasive medical procedures, war, and torture) have also reacted by developing DID.

Survivors of extreme trauma may also have additional parenting problems different from those of people with other psychiatric disabilities. For example, although a minority admit to being abusive, adults who grew up in violent, abusive families typically have no role model for safe and healthy parenting. The normal neediness of a typical young child might be enough to trigger dissociation in a parent with a trauma history, causing the parent to “go away” when she is most needed.

All parents live vicariously, to some extent, through the experiences and activities of their children. Unfortunately, it is not unusual for a dissociative parent to functionally decompensate when their own children reach the age at which he or she was traumatized. Even if the parent does not become functionally impaired, the child’s age, appearance, and behavior may act as a “trigger,” reminding the parent of his or her own childhood abuse and subconsciously causing the parent to respond in a non-nurturing way.

People often ask whether individuals diagnosed with DID actually have more than one personality. The answer is yes, and no. One reason for the name change from Multiple Personality Disorder to Dissociative Identity Disorder is that “multiple personalities” is a misleading term. A person diagnosed with DID *perceives* having within her two or more entities, or personality states, each with its own independent way of relating, perceiving, thinking and remembering about herself and her life. These entities previously were often called “personalities,” even though the term did not accurately reflect the common definition of the word. Other terms often used by therapists and survivors to describe these entities are: “alternate personalities,” “alters,” “parts,” “states of consciousness,” “ego states,” and “identities.” It is important to keep in mind that although these alternate personality states may appear to be very different, they are all manifestations of a single person.

The fluctuations of alternate personality states may be a particular problem for the children of parents with DID. Most parents who have dissociative disorders perceive themselves as “good”

mothers or fathers, and most have nurturing parental alters. A minority, however, are frankly abusive or deliberately hurtful: children may be injured when they are misperceived as someone else, or when an aggressive alter becomes hostile. More commonly, dissociative parents may elope for periods of time, fail to protect their children, and model inappropriate and non-nurturing behavior.

Even in the best of cases, the children are often so attuned to the changes in the dissociative parent's alters that they accommodate their own behavior accordingly. For example, children may learn to promote parental dissociation, encouraging permissive personalities to allow questionable activities, or using periods of parental amnesia to cover misbehavior. In many families with a dissociative parent, the inconsistencies of values, disciplinary codes, memory of daily routines, etc., can severely compromise the safety of the children and the level of function within the family.

The phenomenon of secondary traumatic stress complicates the mental health picture in regard to children with a dissociative parent. Children can be vicariously traumatized by living with a dissociative parent who may be self-destructive or prone to flashbacks of trauma experiences. In addition, dissociative parents may find themselves in revictimizing circumstances, and their children may also be victimized in these situations. For example, it is common for people with histories of childhood victimization to connect with partners who are abusive. This pattern increases the risk to children and step-children.

The standards of practice guidelines of the International Society for the Study of Trauma and Dissociation (ISSTD) suggests that the children of dissociative parents also be evaluated by a professional familiar with the indicators for dissociative disorders and child abuse. These are children who are at risk for a wide variety of psychiatric conditions due to the instability in their families, risk of exposure to violence, and possible genetic factors.

There is some evidence for a biological predisposition to dissociation. Because children of dissociative parents may have been left with extended family members who may be abusive, careful history-taking regarding childcare arrangements is essential. Case studies of children of dissociative parents suggest that even without extreme abuse histories, these children may rely on fantasy and dissociative defenses for coping. Fortunately, if dissociative disorders are diagnosed in children, treatment tends to be quick and successful.

Psychoeducation for children, to familiarize them with their parent's problems, is an important intervention. Parents may have involved children too much, or conversely withheld information from them. Children need to learn to regard the parent's dissociative behavior as a manifestation of an illness, rather than something to be imitated or manipulated. Children in dissociative households may assume parent-like roles in the family to take care of siblings as well as a parent who may regress. Family therapy to reestablish appropriate boundaries is important. Individual therapy for the child should focus on ambivalent feelings about the parents, and deal with traumatic exposure to family violence or witnessing of parental suicide attempts. Other therapeutic interventions might include confirmation of a child's perception of

their parent's changeability and inconsistency; reality-orientation; and crisis intervention (focusing on fears, ambivalence, confusion over a parent's bizarre behavior, and guilt over wished-for removal of the parent).

Dissociative disorders are highly responsive to individual psychotherapy, or "talk therapy," as well as medications, hypnotherapy, and adjunctive therapies such as art or movement therapy. In fact, DID may be the psychiatric condition that carries the best prognosis, if proper treatment is undertaken and completed. The course of treatment is long-term, intensive, and invariably painful, as it generally involves remembering and reclaiming the dissociated traumatic experiences. Nevertheless, individuals with DID have been successfully treated by therapists of all professional backgrounds working in a variety of settings.

Sometimes DID parents involved in custody disputes are portrayed by their partners as "hopelessly mentally ill" and their utilization of therapy is portrayed as a weakness rather than as a strength. In legal proceedings it is extremely important to evaluate each case based on its own merits, using experts as necessary. Many DID patients are excellent parents who have made commitments not to recreate the patterns of abuse that existed in their families of origin. After a proper course of treatment specifically for dissociative disorders, it is possible that even people who have had periods of compromised parenting can be successful and nurturing parents.

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