

# RECOGNITION AND DIFFERENTIAL DIAGNOSIS OF DISSOCIATIVE DISORDERS IN CHILDREN AND ADOLESCENTS

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## ABSTRACT

*An overview of the literature on dissociative disorders in children and adolescents is presented in a way that highlights the emerging clinical profile of the highly complex behavioral and symptomatic presentation of these conditions in childhood. Developmental influences are recognized as playing a role in the diagnostic challenge of differentiating dissociative disorders from more commonly diagnosed childhood conditions. A systematic approach to evaluation and differential diagnosis is described in detail, and misleading symptomatic manifestations of dissociative processes are identified.*

## INTRODUCTION

Children with *DSM-III-R* (American Psychiatric Association, 1987) diagnoses of multiple personality disorder (MPD) and those with dissociative disorder not otherwise specified (DDNOS) are a unique group of young individuals. Since they often present to the mental health system as polysymptomatic, traumatized children with difficult behavior problems (Bowman, Blix, & Coons, 1985; Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Hornstein & Tyson, 1991; Kluft, 1984; Malenbaum & Russel, 1987; Peterson, 1990; Riley & Mead, 1988; Vincent & Pickering, 1988; Weiss, Sutton, & Utrecht, 1985), they represent challenges both to diagnostic acumen and to therapeutic expertise. Frequently, their family, social, and environmental problems are overwhelmingly complex and difficult to address (Hornstein & Tyson, 1991).

Few challenges, however, offer more significant rewards than the recognition and treatment of dissociative disorders (DDs) early in their clinical course. Since it is firmly established that DDs are among the sequelae of early childhood trauma, particularly severe, ongoing sexual abuse (Bliss, 1984; Dell & Eisenhower, 1990; Hornstein & Tyson, 1991; Hornstein

& Putnam, in press; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, et al., 1991; Ross, Norton, & Wozney, 1989; Schultz, Braun, & Kluft, 1989), recognition of these symptoms makes intervention with the child and his or her family possible, preventing a continuation of the abuse. Early, appropriate therapeutic intervention is also highly desirable since there is evidence suggesting that children's dissociative symptoms often respond more rapidly than those of their adult counterparts (Kluft, 1984; 1985; 1986; 1989).

It is easiest to recognize a constellation of symptoms, develop a diagnostic formulation, and approach therapeutic intervention with a patient when there is a readily accessible mental image of the symptoms' developmental significance and the underlying traumas, deficits, and psychodynamic conflicts they attempt to address. It is generally accepted that children develop dissociative disorders as a defense against overwhelming, frequently chronic, physical and/or psychological trauma (Ludwig, 1983; Putnam, 1989; Spiegel, 1991). From an early age, these children's world has been populated by unstable caregivers. They have experienced combinations of physical, sexual, and emotional abuse, have witnessed domestic violence, have had their basic needs for nurturance and protection neglected, and may have experienced overt abandonment as well.

As a result of their unfortunate experiences, these children develop unique ways of surviving and relating to the world. A child's internalization of these highly conflictual experiences with his or her primary caregivers creates unresolvable internal conflicts with different aspects of their identity. To integrate these conflicting identifications (and the associated traumatic memories) would cause overwhelming anxiety, so the child adaptively utilizes his or her creativity and dissociative capacity to defend against anxiety via a subjective experience of having separate selves. These "selves" often become organized around the extremes of response that must be available to the child in order to continue to develop and cope in the face of repeated traumas. Fantasy assists the child in his or her attempts to cope with an overwhelming reality. Since the child must so often focus on the shifting responses demanded by the external world, these children's development of internal regulation of their affects and behavior has been limited. Their attempts to establish intimate relationships are fraught with conflict between an intense longing to be cared for and an equally intense terror that past traumas will be repeated in the present.

Keeping in mind the origin, development, and defensive requirements that brought about the existence of a dis-

sociative disorder (DD) can help to provide an organizing framework for the otherwise perplexing array of dissociative, affective, attentional, behavioral, post-traumatic, and other symptomatology this paper will describe as an integral part of these children's psychiatric presentation.

## REVIEW OF THE LITERATURE

The apparently "new" description of dissociative disorders occurring in children and adolescents is really a re-discovery of conditions clearly described in clinical reports of the 19th and early 20th Centuries (Bowman, 1990; Fine, 1988). Others have elaborated on the factors which resulted in the exclusion of dissociative disorders from clinical awareness during much of the 20th Century (Putnam, 1989; Coons, 1984; Kluft, 1985; Horevitz & Braun, 1984).

Reading clinical case descriptions in the psychiatric literature during this recent eclipse of awareness with regard to cases of dissociative disorders in childhood often turns up symptomatic descriptions of patients that sound similar to contemporary clinical descriptions of dissociative disorder patients. For example, although dissociative defenses are not recognized and identified as such, the child development literature is replete with descriptions of children utilizing defenses readily recognizable as dissociative when they are experiencing extreme degrees of danger and deprivation (Barach, 1991). For an excellent example of such an article, see S. Fraiberg's 1982 *Pathological Defenses in Infancy*. Being armed with a present day knowledge of the symptomatic manifestations of dissociative pathology makes for interesting retrospective theorizing over a variety of literature in which traumatized children are described, including the post-traumatic stress disorder (PTSD) and child abuse literatures. I often find clinical descriptions that virtually compel speculation about missed diagnoses of dissociative disorders. A more in-depth treatment of this theory is not possible here, but in the future may help provide answers to the puzzling question, "Where have these cases been for the last one hundred years?"

Research on dissociative disorders in childhood has lagged somewhat behind the burgeoning adult DD literature. Until very recently, a low index of suspicion among child clinicians and the absence of substantiated clinical profiles of childhood DDs made it difficult to differentiate these complex, polysymptomatic cases from more commonly diagnosed childhood conditions (Kluft, 1985; Putnam, 1991; Hornstein & Tyson, 1991). Normative dissociation changes enormously over the course of development. Putnam (1985) and Steinberg (1991) separately describe elements of these changes, including the shifts in attention, forgetfulness, and contextually-determined sense of identity common in young children, and the transient depersonalization experiences common in adolescents. The younger the child, the more complicated it is to determine pathological levels of dissociation.

Kluft noted the inherent limitations childhood social and economic realities place on opportunities for a MPD child's alternate personalities (alters) to express their separateness and that additionally, adolescent development

includes the emergence of adult sexuality, and a coalescence of identity along with separation/individuation tasks, all of which may influence the symptomatic expression of MPD (Kluft, 1984; 1985). It bears emphasizing that a child's access to the mental health system requires the involvement of parents or other guardians. Given the family dysfunction associated with the development of DDs, this factor is likely to both limit the number of cases presenting in childhood and influence the nature of the cases that do present. In a recent article on inpatient treatment of children with DDs, we point out that a number of cases presented for treatment through foster or residential care placements after being removed from their homes because of documented abuse (Hornstein & Tyson, 1991).

The initial interest in identifying childhood cases of DDs arose from clinical experience with adult MPD patients who not only recounted experiences of severe childhood trauma, but also described the childhood onset of their disorder. Kluft in 1978, and Putnam in 1981 pioneered the effort to identify childhood cases of DDs through the development of childhood MPD predictor lists (Kluft, 1984). Kluft followed with the first published description of a small clinical series of children treated for MPD (Kluft, 1984), and was joined that same year by Fagan & McMahon's description of "incipient multiple personality disorder" in childhood (Fagan & McMahon, 1984). As documentation increased that the vast majority of adult dissociative patients reported experiencing severe early childhood trauma (Chu & Dill, 1990; Coons, Bowman, & Milstein, 1988; Greaves, 1980; Putnam et al., 1986; Ross et al., 1990; Ross et al., 1989; Schultz et al., 1989; Stern, 1984), interest in this area further intensified. This has resulted in the increased publication of single case reports and small case series of child and adolescent DDs (Bowman et al., 1985; Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Hornstein & Tyson, 1991; Kluft, 1984; Malenbaum and Russel, 1987; Peterson, 1990; Riley & Mead, 1988; Vincent & Pickering, 1988; Weiss et al., 1985).

Recently, Putnam and I reported a large case series that compares systematically gathered clinical data on two separately diagnosed samples of children and adolescents with dissociative disorders (64 cases — 44 MPD and 20 DDNOS) (Hornstein & Putnam, 1992). Our study was undertaken to further delineate the clinical phenomenology of child and adolescent dissociative disorders. In Table One, you will find on the far right an overview of some of this study's findings along a longitudinal axis consisting of the most common symptoms organized into seven general categories by type of symptom. There are two additional categories for documenting the trauma/abuse history and other pertinent historical data. Table One also contains the childhood MPD predictor lists noted above, developed by Kluft and Putnam, and the symptoms inquired about on the child dissociative checklist developed by Putnam (version 2.2), which allows for systematic inquiry into childhood dissociative symptoms with the child's caregivers (Putnam, 1988). These are included in the table in order to show: (1) how closely the symptomatic profiles of these children corresponded to earlier clinical expectations, previously reported child and adult MPD cases; and (2) to give an expanded clinical profile of

children with MPD. Clearly only an overview of the study's findings will be presented here to assist description of the symptomatic profile of the dissociative child, those interested in the study methodology and statistical analysis of the data may refer to our paper.

### CLINICAL PROFILE OF DISSOCIATION IN CHILDHOOD

As can be readily surmised from a brief study of Table One, children who meet *DSM-III-R* criteria for the diagnoses of MPD are characterized by the abundance of anxiety, attentional, affective, conduct, post-traumatic, dissociative, and psychotic-like symptoms with which they present. Children with DDNOS had a very similar profile. Children with MPD differed from their DDNOS counterparts by having more amnesia (100% of cases vs. 46%), alternate personalities (100% vs. 5%), and hallucinations (97% vs. 75%). Significantly, the children with MPD were more likely to have amnesias not related to traumatic events and were more likely to "lose time" during the day. Adolescents were more symptomatic than were children under eleven, and were more likely to receive a diagnosis of MPD. Children with MPD made significantly more serious suicide attempts ( $p=.01$ ).

The average child in this series had received  $2.7 \pm 1.3$  prior psychiatric diagnoses. The most common diagnoses were major depression or depressive psychosis (45.3%), PTSD (29.6%), oppositional defiant disorder (17%), conduct disorder (14%), and attention deficit hyperactivity disorder (12.5%). The symptom constellation of depression, suicidality, hallucinations, and behavioral problems associated with these children's prior diagnoses is strikingly congruent with the symptomatic presentation of DDs in adulthood (Bliss, 1984; Coons et al., 1988; Hornstein & Tyson, 1991; Kluft, 1991; Putnam et al., 1986; Ross et al., 1990; Ross et al., 1989; Schultz et al., 1989).

Children with DDs had high rates of auditory hallucinations. These resembled the auditory hallucinations reported by their adult DD counterparts in that they were ordinarily experienced as originating from within, and were described as having distinctively qualities such as age, gender, and personal attributes (e.g., "I hear a voice just like Uncle Bob's, who tells me I'm bad and should kill myself."). Other psychotic-like experiences, such as passive influence experiences, thought insertion and withdrawal, and episodes of disorganized thinking and confusion were present in over half the MPD children, and somewhat less frequently in those with DDNOS. None of the children had a persistent thought disorder. These psychotic-like experiences are similar to those reported by adult MPD patients (Fink & Golinkoff, 1990; Kluft, 1987; Ross et al., 1990). Ideas that could be classed as delusional were present in 17% of the sample. On inquiry, these "delusions" were often identifiable as attempts by the child to explain dissociative phenomenon. For example, an eight-year-old girl believed that beings from outer space had selected her for a special mission. She described hearing several voices but also said the beings gave her magic signs through changing channels on her TV set. It turned out that she dis-

sociated frequently and was amnesic for changing channels on the TV as well as for many other activities.

The DD children in this sample were easily distinguished diagnostically from children with schizophrenia or other psychotic illnesses. In some cases, the presence of florid post-traumatic and dissociative symptoms were the impetus for closer examination of what had previously been diagnosed as a psychotic illness. Often it had been the presence of auditory hallucinations and passive influence phenomena that led to the earlier diagnosis. Interestingly, Russel, Bott, and Sammons (1989) reported much lower rates of control/influence (9%), thought insertion (11%), and higher rates of delusions (63%) in their sample of thirty-five schizophrenic children than are present in our sample. Discriminatory diagnostic variables between childhood schizophrenia and DDs should be pursued in further studies.

The rapidity of age regression phenomena and shifts in demeanor and personality characteristics were salient features of both groups of dissociative children. All of these children entered into "trance-like" states, where they were oblivious to normal external stimuli. Most of these children, therefore, had evaluations at some point for petit mal, partial complex, or other forms of seizure disorders. All of the electroencephalograms (EEGs) were normal. Since seizure disorders may be diagnosed and treated in the absence of demonstrable EEG abnormalities, efforts should be made to differentiate true seizures from dissociative phenomena in DD children previously diagnosed with epilepsy.

Dissociation, with its interruptions in consciousness, variations in skills, knowledge, and abilities, and its common association with affective, anxiety, and post-traumatic symptoms (hyper-arousal, etc.) often produces learning and reading problems, difficulties with attention and concentration, and other school problems. The undiagnosed dissociative disorder child may appear symptomatically similar to a child with attention deficit hyperactivity disorder in the classroom. The trance states and variations in school performance seen in this case are in keeping with previously reported child and adolescent case studies and clinical series (Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Kluft, 1985; Riley & Mead, 1988; Weiss et al., 1985), as are the behavioral disturbances leading to diagnoses of oppositional defiant and conduct disorders (Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Kluft, 1984; Malenbaum & Russel, 1987; Peterson, 1990; Riley & Mead, 1988; Weiss et al., 1985).

A substantial majority (95.3%) of the children in our sample had documented histories of some combination of types of abuse. This high rate of abuse is congruent with prior adult (Bliss, 1984; Putnam et al., 1986; Ross et al., 1989; Schultz et al., 1989) and child and adolescent DD case reports and series (Bowman et al., 1985; Dell & Eisenhower, 1990; Fagan & McMahon, 1984; Hornstein & Tyson, 1991; Kluft, 1984; Malenbaum & Russel, 1987; Peterson, 1990; Riley & Mead, 1988; Vincent & Pickering, 1988; Weiss et al., 1985).

### DIAGNOSTIC EVALUATION

In my clinical experience, it is usually *not* the child's dissociative symptoms that prompt caregivers to seek psychi-



TABLE 1  
Profile of childhood dissociation

MPD Predictors & Child Dissociative Checklist (C.D.C.) Comparison with each other and large case series.	Kluft, 1978, 1984	Putnam, 1981	C.D.C. (Sx's of inquiry, questions paraphrased (Putnam, 1988)	Hornstein, Putnam, (in press) 44 children MPD
<b># Items</b>	<b>16</b>	<b>13</b>	<b>16</b>	<b>100</b>
Trauma/abuse Hx	—	Sustained, repeated abuse	—	95.3% of cases had documented hx. of comb. of physical and sexual abuse, neglect, abandonment and/or domestic violence.
Historical Data a) Family hx. Dissociation b) Tx. refractory c) Other DSM Dx.	Dissociator in family Refractory to previous Tx. Other DSM Dx. possible.	—	—	Average of 2.7 ± 1.3 prior Dx.
Mood/Anxiety Sx	Intermittent depression. Fluctuation in mood.	—	—	Depression — 85% Anxiety — 100% Labile mood — 96% Suicidal ideation — 65%
Conduct and behavioral Sx.	Disavowed witnessed behavior. Disavowed polarized behavior Called a liar.	Self-mutilation	Lies/denies inappropriate sexual behavior. Unexplained injury/self- mutilation. Intense anger outbursts.	Lies/denies > 90%. Inappropriate sexual behavior > 60%. Self-mutilation > 40%. Explosive temper > 95%.
Attention and school difficulties	Fluctuation in ability, age-appro- priateness. Inconsistent school behavior.	Marked variation in ability.	Forgetful/ confused. Marked variations in skills, knowledge, etc. Difficulty learning from experience.	Variations in knowl- edge, skills > 90%. Problems with concen- tration/distractibility > 95%

TABLE 1 • Continued from previous page  
Profile of childhood dissociation

PTSD Sx	—	—	—	Hypervigilance > 85%. Hypersartle > 86%. Traumatic nightmares > 86%. Flashbacks > 60%. Intrusive thoughts > 70%.
Dissociative Sx.	Autohypnotic/ trance-like behaviors. Amnesia. Passive influence experiences, (phenomena suggesting). Muted signs of adult MPD. Attenuated expressions of MPD.	Amnesic for abuse; Amnesia/denial. Talk to imaginary playmate older than 3 years. Rapid regres- sion/variation. Frequently sleep- walks. Refers to self in third person.	Rapid change in personality. Amnesic or denies traumas have occurred. Daze or trance states. Poor time sense/time loss Rapid age regression. Refer to self in third person. Vivid imaginary companion.	100% had rapid changes in personality, alternate personalities, rapid age regression and amnesia. >60% had passive influences. >90% third person reference. >80% amnesia known 'trauma.
Hallucinations/ thought disorder Sx.	Hallucinated voices.	Auditory hallucinations	Hearing voices talking.	>95% had auditory hallucinations. >70% confusion. >60% disorganized thinking. >50% had thought insertion.
Somatoform Sx.	—	Hysterical Sx. Rapidly fluctuating physical complaints.	Rapidly changing physical complaints.	—

TABLE 2  
Dissociative symptoms mistakenly attributed to other diagnoses

Dissociative Symptoms	Behavioral Appearance	Misdiagnosis
Brief amnesic periods	"Trance-like" odd behavior, explosive outbursts Poor attention, concentration, hyperarousal. Disavowal of witnessed behavior.	Absence/psychomotor seizures. Attention deficit with hyperactivity. Conduct disorder.
Switching between alternate personalities	Aggressive alters, running away, truancy. Alters differ in task performance, academic achievement, other skills.	Conduct disorder. Developmental learning disorder.
Affect disturbances	Different alters may have different mood, depressed/suicidal and excited alters not uncommon. Symptoms of post-traumatic stress disorder, including problems sleeping related to hyperarousal/nightmares common.	Affective disorders
Thought process disturbances	Alters experienced as hallucinated voices, visual hallucinations of past trauma, alters, partial control by alter similar to passive influence. Rapid switching causes discontinuity in stream of thought.	Psychotic illness
Somatoform Symptoms	Headaches commonly accompany switching. Parasthesias, somatic hallucinations, conversion symptoms, odd moments, etc.	Somatoform disorders Tic disorders
Anxiety	A high level of anxiety or accompanying post-traumatic stress disorder is common in dissociating children.	Primary anxiety disorder
Post-traumatic stress disorder		

(Hornstein & Tyson, 1991)

atric evaluation. The presenting complaint is more frequently depression or behavioral and school problems. It is therefore important to inquire about past traumatic/abuse experiences in virtually all children presenting for mental health or behavioral problems. I routinely employ screening questions designed to identify dissociative symptoms in all my diagnostic evaluations. The Child Dissociative Checklist (Putnam, 1988) is an easy and quick screening tool useful for identifying children who should be further evaluated for the presence of a dissociative disorder.

Any child with a history of physical and/or sexual abuse should receive a thorough evaluation for the presence of a dissociative disorder. When the abuse was repetitive, began in early childhood, was unusually sadistic, involved ritualized religious practices, or involved threats of death and/or threatened/actual physical/sexual injury, disease, pregnancy, multiple caregivers, or parents with psychotic/sociopathic illnesses, extended observational and historical data should be obtained from all adults in day-to-day contact with the child. This should accompany a careful diagnostic interview and a period of observation over several sessions and in different settings, if possible. Children who dissociate often have significant behavioral inconsistencies that occur between settings or during observations conducted over extended periods of time. These observations can then be followed up therapeutically with the child, and the child can be assisted to discuss the problems he or she is experiencing more fully.

Such in-depth data-gathering from many sources and extended observation in different settings is often necessary where there are symptoms suggesting the possibility of a dissociative disorder, but more routine evaluations have been unable to arrive at a definitive diagnosis.

Children whose parents themselves suffer from a dissociative disorder should be screened on a regular (yearly) basis while the parents remain symptomatic. A number of authors have reported an increased incidence of DDs in families where another family member has a dissociative disorder (Braun, 1985; Coons, 1985; Hornstein & Tyson, 1991). As reported elsewhere (Hornstein & Tyson, 1991), an inpatient sample of children with DDs revealed a 25% incidence of DDs in parents. This number is likely lowered due to the absence of parental information on a number of the cases. A majority of these children's parents had histories of physical/sexual abuse in their own childhoods.

I continue to identify DDs in children where I least expect it. In fact, my favorite demonstration tape of an interview with an MPD child began with a 50-minute inquiry into his presenting depressive and conduct symptoms. It was only towards the end of the interview, while pursuing a seemingly off-hand remark made by the child, that his rather florid dissociative symptoms came to light. This child had spent several weeks on my inpatient service, right under the nose of myself and a number of other professionals highly experienced in recognizing dissociative symptoms without any of us having the dimmest suspicion of his having MPD. These and similarly embarrassing experiences have informed my practice of routine inquiry about dissociative symptoms.

In obtaining a history to rule out dissociation, the information contained in a year-by-year history of the child's life can guide observations and assist in developing diagnostic and dynamic formulations. Data about the child's caregivers, the nature of family stressors, details of the living environment, the child's behaviors, developmental milestones attained (or lost), emergence of symptoms, along with careful descriptions of each symptom, including precipitating and ameliorating factors should be obtained. Descriptions of traumatic experiences should indicate the time-frame and circumstances surrounding them which include experiences of physical and sexual abuse, hospitalizations, extensive medical treatment, witnessing family violence, loss or separation from caregivers (including their hospitalizations, suicide attempts, periods in drug treatment, jail, etc.). Symptoms and behaviors that may represent dissociative experiences should be explored in depth. Information about psychiatric symptoms in family members, including dissociative experiences, childhood trauma/abuse, and substance abuse can also be important in directing an evaluation.

Experience interviewing children about their internal world is inordinately helpful when making direct inquiry with them about dissociative symptoms. The child's age and developmental level profoundly influence the ways in which he or she recounts his or her experience. Interviewing children without dissociative disorders is helpful for developing a clinical impression about what are or are not normative responses to questioning. I have all too often been asked to evaluate fairly average youngsters after an inexperienced clinician became overly concerned about their active fantasy life. The child and I enjoyed ourselves, but their parents were often distraught over the implications of the referral.

Children younger than pre-adolescence have difficulty with abstract concepts and are notorious for their difficulty placing events in time. This proves challenging when attempting to ask about amnesia and "time loss" experiences. The most successful approach involves authoring inquiry in the events of their daily life. I ask them whether they ever have experiences that are similar to a description of mine, such as being confused that the teacher is in the middle of writing math problems on the board when the last thing they knew she was reading them a story, or whether they do not remember eating lunch some days, or if, when they ask to do something, people tell them "you just did that," but they do not remember doing it, etc. I then get the child to describe in his or her own words experiences like this he or she has had.

In attempting to differentiate dissociative experiences from "lies," it can be helpful to ask the child if he ever got thanked for or told he did something helpful that he did not recall and to get an idea of the frequency with which this occurs. Children who dissociate are frequently amnesic for emotionally laden experiences such as explosive outbursts or yard fights. A useful approach is to ask whether they remember "the whole thing" or "have blanks," and to find out if they really remember these experiences or only know what they did because someone told them afterwards.



These are the occasions for which they most frequently describe control/influence phenomena (e.g., "my arm was just hitting him, I was saying no to my arm but it kept on going, while a voice was telling me to butt out.").

A patient, inquiring approach to the child with careful attention to whether what he or she is saying is understood correctly is the most important ingredient in successful interviews. Observing the child for signs of dissociation during the interview and careful questioning about what the child is experiencing, often yields additional information about dissociative experiences.

## DIFFERENTIAL DIAGNOSIS

The central differential diagnostic task that confronts the clinician with a DD child is sorting through and distinguishing between dissociative and other symptoms and behaviors that suggest or mimic other psychiatric disorders. Table Two is reprinted with permission from a recent article (Hornstein & Tyson, 1991) to provide an overview of symptoms frequently found in dissociating children (Hornstein & Putnam, in press) that may superficially appear to represent other diagnoses.

Although children with dissociative disorders may also have seizures, developmental learning disorders, or other diagnoses, recognition of dissociative symptoms is key to successful treatment. That is why so much of this paper is devoted to a description of the clinical profile of childhood dissociative disorders and to methods that can assist in the discovery of dissociative symptoms.

Once the presence of a DD is established, it may take some time to establish how individual symptoms do or do not relate to the dissociative diagnosis. It is prudent to begin psychotherapy and observe symptomatic changes before attempting to alleviate or ameliorate specific symptoms through pharmacologic intervention.

## SUMMARY

Children with dissociative disorders have complex, polysymptomatic presentations that resemble those of their adult counterparts. Developmental variables not only influence symptom expression, but add to the diagnostic challenges these youngsters present to the mental health profession. Emerging clinical profiles of childhood DDs combined with systematic diagnostic approaches enable clinicians to recognize dissociative symptomatology, identify children who should be evaluated, and organize an otherwise baffling array of symptoms and behaviors to arrive at a diagnosis of these conditions when present in children.

Increasing recognition of children with DDs will allow for intervention to prevent ongoing abuse, and enable these children to receive effective treatment. ■

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