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A Collective Case Study of the Diagnosis of Dissociative Disorders in Children

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A Collective Case Study of the Diagnosis of Dissociative
Disorders in Children

by

Jacqueline J. Reycraft

A dissertation submitted in partial fulfillment
of the requirements of the degree of
Doctor of Philosophy
Department of Counselor Education
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Dissociation, Somatoform Dissociation, Trauma

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Dedication

This dissertation is dedicated to “Emily”, “Tyler”, and their families. May this work make a difference in the lives of others as you have made a difference in my life.

Acknowledgments

My unspeakable gratitude goes out to all the people who have given me the support and encouragement I needed through this doctoral process. My husband, Ron, has walked this journey with me, sometimes jumping ahead of me to clear the path, sometimes stepping behind to catch my fall, but always beside me sharing my tears and fears as well as my laughter and joy. Thank you for your love and support always.

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Abstract

There is a paucity of research on the diagnosis of dissociative disorders in children. Most children are misdiagnosed with more common mental disorders with similar symptoms. Earlier recognition of dissociative disorders can save years of pain, suffering, and cost. This qualitative collective case study examined the process of diagnosing dissociation in two children under the ages of 12 at the beginning of treatment. A concurrent focus on the training and development of the therapist/researcher is included. Archival data including progress notes, psychotherapy notes, assessments, correspondence, legal documents, school records, and medical records were analyzed using within-case and cross-case analyses to identify individual and common themes that may expedite the diagnosis of dissociative disorders in children. The narrative presentation of a qualitative study with its thick, rich description may increase the understanding of clinicians with little or no experience and help them to differentiate these disorders from other disorders with overlapping symptoms. Factors that impeded and advanced the recognition of dissociative disorders were identified. Clinical findings underscore the role of knowledge and training, experience, and consultation in the diagnosis of dissociative disorders.

Chapter One - Introduction

Dissociation is widely viewed as a process that occurs on a continuum from normal to pathological (Van der Hart & Dorahy, 2009). A normal process of dissociation may occur while engaging in an automatic activity like driving. However, when dangerous situations arise, dissociation may be used as a defense mechanism to survive the overwhelming experience. Repeated use of dissociation as a protective mechanism may develop into a pathological dissociative process that results in a dissociative disorder (Carlson, Yates, & Sroufe, 2009; Wieland, 2011).

Dissociative disorders are described in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, (DSM-IV-TR; American Psychiatric Association [APA], 2000) as “a disruption in the usually integrated functions of consciousness, memory, identity, or perception” (p.519). Dissociative disorders include four main diagnostic categories in the DSM-IV-TR: Dissociative Amnesia, Depersonalization, Dissociative Fugue, and Dissociative Identity Disorder (DID). Perhaps because it is considered the most severe of the diagnoses (ISSTD, 2012), much of the literature appears to focus on DID. A fifth category, Dissociative Disorder Not Otherwise Specified (DDNOS), is used for clients who present with a predominant dissociative symptom, but who do not completely meet the criteria for one of the other dissociative disorders, especially DID (APA, 2000; ISSTD, 2012).

Dissociative disorders, especially DID, produce a variety of medical, psychiatric, and neurological symptoms that are resistant to standard treatments (Putnam, 1989;

Putnam, Guroff, Silberman, Barban, & Post, 1986). These symptoms cause considerable suffering, pain, and distress to those affected, as well as impacting others and incurring immense expenses (Fagan & McMahon, 1984; Kluft, 1984a; Silberg, 2000). Kluft (1984a) reports it takes an average of nearly seven years for adult patients to be diagnosed correctly, and treatment duration of more than 10 years is not unusual.

In the past it was thought that dissociative disorders were rare, and some questioned the existence of DID (Putnam, 1989). However, recent literature indicates that dissociative disorders may occur more and may even be under diagnosed. A review of studies of inpatient populations in various countries shows prevalence rates of dissociative disorders from 4% – 21% and DID from 1% - 7% (Friedl & Draijer, 2000; Gast, Rodewald, Nickel, & Emrich, 2001; Horen, Leichner, & Lawson, 1995; Latz, Kramer, & Hughes, 1995; Lussier, Steiner, Grey, & Hansen, 1997; Tutkun et al., 1998).

A smaller number of studies have been done with outpatient populations. Two of the studies noted methodological limitations (Bliss & Jeppsen, 1985; Graves, 1989), but in another outpatient study, Sar, Tutkun, Alyanak, Bakim, & Baral (2000) found that dissociative disorders were present in 12% of the sample. Four percent were diagnosed DID and 8% were diagnosed DDNOS. Of patients who had been given a previous diagnosis, only 1% had been diagnosed with a dissociative disorder. Foote, Smolin, Kaplan, Legatt, & Lipschitz (2006) conducted a similar study whereby they administered several self report instruments. However, they did not use any instruments to screen out participants as Sar et al. (2000) did, but attempted to interview all of those who were admitted. They diagnosed a dissociative disorder in 29% of the patients; only 5% had been given a previous diagnosis of a dissociative disorder.

Dissociative disorders were first described as early as 1791. The first case of DID, formerly known as Multiple Personality Disorder (MPD), was documented in 1816 (Ellenberger, 1970). Since that time, hundreds of adult cases of DID have been reported with increasing frequency (Boor, 1982; Kluft, 1987; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, 1997), and the literature on diagnostic tools, research, theory and treatment of adults with dissociative disorders has grown (Carlson et al., 1993; Chu, 2011; Kluft & Fine, 1993; Michelson & Ray, 1996; Putnam, 1989; Putnam & Loewenstein, 2000; Ross et al., 1990; Ross, 1997; Steele, Van der Hart, & Nijenhuis, 2005).

Unfortunately, in contrast to the proliferation of adult literature, the literature pertaining to the diagnosis and treatment of dissociative disorders in children remains comparatively scarce (Silberg, 2000). Three findings from adult research demonstrate the need for more research on dissociative disorders in children. First, childhood trauma has been highly correlated with high levels of dissociation or dissociative disorders in adults and children (Chu & Dill, 1990; Coons, Bowman, & Milstein, 1988; Drajer & Langeland, 1999; Putnam et al., 1986; Ross, Norton, & Wozney, 1989; Zlotnick, Shea, Pearlstein, Begin, Simpson, & Costello, 1996). Secondly, in the majority of the adult cases, DID was reported to begin in childhood, with the presentation of alters occurring before age 12, and most frequently between the ages of 4 and 6 years (Bliss, 1980; Putnam et al., 1986; Putnam, 1997). Lastly, existing research indicates that treatment can be completed in a shorter time with children than with adults (Fagan & McMahon, 1984; Kluft, 1985b, 1985d). These findings highlight the need to be able to more accurately

diagnose dissociative disorders in childhood in order to provide effective treatment “so that pathological processes can be interrupted” (Silberg, 2000, p. 119).

However, diagnosing dissociative disorders in children is a major obstacle, and an inability to correctly diagnose dissociative disorders also impedes the ability to provide effective treatment. Kluft (1985a) discussed several possible explanations for the difficulty in diagnosing DID in children. One reason given by Kluft is that DID in children presents itself differently from adults. Other researchers have also noted that symptoms in children are different from those in adults (Fagan & McMahon, 1984; Peterson, 1991). This difference is not currently addressed in the DSM-IV-TR criteria for dissociative disorders (APA, 2000). Other explanations are that some dissociative symptoms in children may be perceived as developmentally normal, e.g. imaginary friends; children may not report symptoms because they do not know they are abnormal; and children may not report symptoms for fear of reprisal or disbelief (Kluft, 1985a). Hornstein and Tyson (1991) found that many cases of dissociative disordered children were found out only after the children were removed from their parents due to abuse and placed in foster care.

Kluft (1985a) also stated “no index of suspicion by treating professionals” (p. 173) as a factor; clinicians were skeptical about the credibility of diagnosing DID or were unfamiliar with it. Therefore, other more common diagnoses are often given. Children are often misdiagnosed with attention deficit hyperactivity disorder (ADHD), anxiety, depression and other affective disorders, posttraumatic stress disorder (PTSD), conduct disorder, oppositional defiant disorder (ODD), conversion and somatoform disorders, schizophrenia, borderline personality disorder (BPD), and even epilepsy (Hornstein,

1993; Nemzer, 1998; Peterson, 1998; Zoroglu, Yargic, Tutkun, Ozturk, & Sar, 1996).

Historically, most cases of DID are misdiagnosed for years (Coons, 1984) and often are not diagnosed correctly until adulthood (Peterson, 1990).

Models and theories have been developed to help explain the development of dissociation in adults. Some of these focus on a developmental perspective that may be applied to the development of dissociation in children. Although no single model or theory can completely explain the phenomenon of dissociation, all of them have something to contribute to our understanding of it. These models and theories identify two common factors as being relevant in the development of dissociation: (a) the existence of chronic trauma in childhood and (b) the significance of the attachment relationship (Putnam, 1997; Liotti, 1992, 1999, 2009; Van der Hart, Nijenhuis, & Steele, 2006).

Statement of the Problem

Research on the diagnosis of dissociative disorders in children remains scarce. The literature indicates that most cases of DID are misdiagnosed for years (Coons, 1984) and often are not diagnosed correctly until adulthood (Peterson, 1990). Diagnosis and efficacious treatment at an earlier age may alleviate years of pain and suffering for children and adults.

Purpose of the Study

The purpose of this study is to examine cases from the beginning of treatment to explore how the diagnosis of a dissociative disorder evolved and to identify any common themes that may help to diagnose dissociative disorders in children. This examination of cases may help counselors with little or no previous experience with dissociative children

to increase their ability to assess and differentiate dissociative disorders from other disorders with overlapping symptoms.

Research Questions

The research will be guided by the following questions:

1. How can dissociation be recognized earlier in children?
2. What common themes may help in the early diagnosis of a dissociative disorder?

Assumptions of the Study

Two assumptions will guide this study. A primary assumption is that a lack of training in identifying dissociative disorders results in a lack of suspicion (Kluft, 1985a) and leads to a delayed diagnosis or a misdiagnosis of dissociative disorders in children. The lack of training and consideration of dissociative disorders means they are often overlooked in the differential diagnosis of children due to symptoms that are common to other diagnoses. It is also assumed that identification of common themes in the cases presented could lead to a more expedient diagnosis of dissociative disorders in children.

Conceptual Framework

The conceptual framework that was initially used to guide this study is depicted in Figure 1 on the next page. It is based on the relationship of trauma and the attachment relationship to the development of dissociation. Although trauma is highly correlated with dissociation, not all traumas result in dissociation (Van der Hart et al., 2006). Children who have experienced repeated positive interactions with a parent, or primary caregiver, develop a secure attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982, 1973, 1980). If a trauma occurs within a parent-child relationship with a secure attachment, the parent is able to provide the support the child needs to

minimize the impact of the trauma. However, some parents or caregivers with their own unresolved trauma may behave in either frightened or frightening ways to a child, producing a disorganized attachment (DA; Main & Hesse, 1990). When trauma occurs, a child with DA and lack of caregiver support is more susceptible to the development of dissociation.

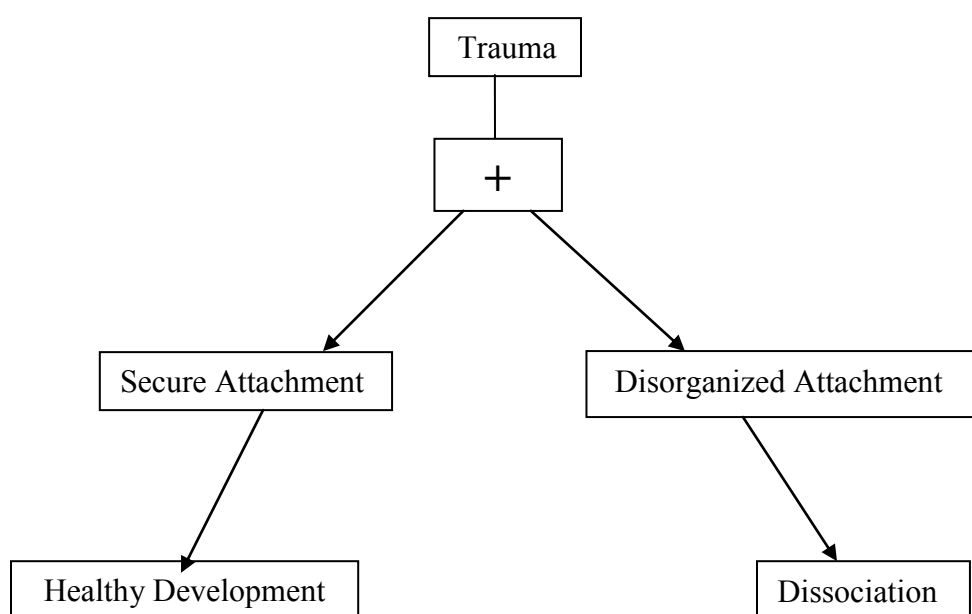


Figure 1. Relationship between trauma, attachment, and dissociation.

Definitions of Major Terms

Alter. “A generic term for any personality or fragment useful because, in clinical situations, it is often unclear...whether an entity is sufficiently distinct and elaborate for a more precise label” (Kluft, 1984b, p. 23).

Attachment. A “lasting psychological connectedness between human beings” (Bowlby, 1969, p.194).

Child. For the purposes of this study, a child will be considered to be a youth under the age of twelve.

Depersonalization Disorder. Depersonalization Disorder “is characterized by a persistent or recurrent feeling of being detached from one’s mental processes or body that is accompanied by intact reality testing” (APA, 2000, p. 519). According to Putnam (1997), it “is the sense of unreality of the self, or parts of the self” (p. 86).

Derealization. Derealization “is the sense of a loss of reality of the immediate environment” with intact reality testing (Putnam, 1997, p. 86).

Disorganized attachment. An attachment pattern observed by Main and Solomon (1990) in which infants displayed an array of unexplainable, conflicting, unusual, disorganized and disoriented behaviors when the parent was present, e.g., looking away while approaching the parent, a dazed expression, sudden interruptions in movement. Main and Hesse (1990) postulated that parents with unresolved trauma memories may behave in either a frightening (maltreating) or frightened (alarmed) way toward the child. The parent may hurt the child at times and offer comfort at other times. The parent may also become frightened by intrusive memories from their own unresolved trauma.

Dissociative disorder. “A disruption in the usually integrated functions of consciousness, memory, identity, or perception” (APA, 2000, p. 519).

Dissociative Identity Disorder. “Dissociative Identity Disorder (formerly Multiple Personality Disorder) is characterized by the presence of two or more distinct personality states that recurrently take control of the individual’s behavior accompanied by an inability to recall important personal information that is too extensive to be ex-

plained by ordinary forgetfulness. It is a disorder characterized by identity fragmentation rather than a proliferation of separate personalities” (APA, 2000, p. 519). The terms DID and MPD will be used interchangeably.

Dissociative Disorder Not Otherwise Specified. This term is used to describe “disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific Dissociative Disorder” (APA, 2000, p. 519).

Secure attachment. “A love relationship that is caring, is reciprocal, and develops over time. Attachment provides nurturance and guidance that foster gradual and appropriate self-reliance, leading to mastery and autonomy” (James, 1994, p. 24).

Shame. “Shame is the uncomfortable or painful feeling that we experience when we realize that a part of us is defective, bad, incomplete, rotten, phoney, inadequate or a failure. In contrast to guilt where we feel bad from doing something wrong, we feel shame from being something wrong or bad” (Whitfield, 1989, p. 44).

Trauma. “Overwhelming, uncontrollable events that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety and loss of control” (James, 1989, p. 1).

Scope and Delimitation of the Study

Participants for this study will be children under the age of twelve at the beginning of treatment. Participants will be selected based on the identification of a dissociative disorder or dissociative symptoms at some point during their treatment regardless of the initial diagnosis.

Summary

This chapter presented an introduction to dissociative disorders. The statement of the problem described the difficulty in diagnosing and treating dissociative disorders in children. A conceptual framework for this study was described and major terms were defined. A qualitative study may add to the existing body of knowledge by examining how dissociation is recognized in children and identifying any common themes that may help in the diagnosis.

Organization of the Study

Chapter One provided an overview of dissociative disorders and the issue of diagnosing and treating them in children. Chapter Two will review the literature on dissociation that is relevant to the study. Chapter Three will describe the methodology that will be used in the study. Chapter Four will present the results of the data analysis, and Chapter Five will provide a summary of the findings of the study with conclusions and recommendations for future research.

Chapter Two - Literature Review

This chapter begins by providing information pertaining to the etiology and epidemiology of dissociative disorders in children as a foundation for this study. Literature relevant to the diagnosis of dissociative disorders in children is presented including the background on the development of diagnostic criteria, a description of the assessment process and the assessments used in the screening of dissociative disorders in children, the assessment of dissociative symptoms, and the differential diagnosis of dissociative disorders from other disorders. A review of the treatment research to date is then provided with attention to how and when a dissociative disorder was diagnosed. Developmental models and theories of dissociation that contribute to our understanding of dissociative disorders in children are also described.

Etiology of Dissociative Disorders

Early studies with adults concurred that MPD begins in childhood (Greaves, 1980; Boor, 1982; Putnam et al., 1986; Stern, 1984; Kluft, 1985c). The majority of adults with dissociative disorders reported severe trauma in childhood (Chu & Dill, 1990; Greaves, 1980; Putnam et al., 1986; Ross et al., 1990, Stern, 1984). Childhood cases have also documented a high percentage of traumatic histories (Coons, 1994; Hornstein & Putnam, 1992; Klein, Mann, & Goodwin, 1994; Silberg & Waters, 1996).

Trauma appears to be a major correlate of dissociation, however, trauma is a subjective construct. What may be considered traumatic to one individual may not be traumatic to another (Wieland, 2011). Documented traumas in childhood cases of

dissociative disorders include physical and sexual abuse (Coons, 1996; Hornstein & Putnam, 1992; Macfie, Cicchetti, & Toth, 2001; Trickett, Noll, Reiffman, & Putnam, 2001), neglectful parenting (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997), inconsistent and rejecting parenting (Mann & Sanders, 1994), natural disasters (Laor et al., 2002), and war trauma (Cagiada, Camaido, & Pennan, 1997). Other childhood cases have involved witnessing domestic violence, emotional abuse, peer rejection, recurrent loss of attachment figures, unstable living environments, and painful medical procedures (ISSD, 2004; Wieland, 2011).

Rhue, Lynn, and Sandberg (1995) conducted a study in response to the abundance of retrospective studies on childhood abuse in MPD adults. They sought to explore whether sexually abused children demonstrated more dissociative symptoms than non-abused children, and whether there was an association between dissociation and measures of imagination and fantasy. In a sample of 39 children seen at a clinic, 12 were sexually abused. The remaining 27 subjects were diagnosed behavior disordered or adjustment disorder. They discovered that 9 of the remaining children were physically abused, and the remaining 18 children were not abused.

Several assessments were administered over two sessions: the Childhood Fantasy Inventory [no citation provided], Tellegen's Absorption Scale (Tellegen, 1982), the Inventory of Creative Memories and Imaginings for Children (Meyers, 1986), and the Children's Perceptual Alteration Scale (CPAS; Evers-Szostak & Sanders, 1990) which is further discussed in the assessment section, human figure drawings, and the Wechsler Intelligence Scale for Children-Revised (WISC-R; Wechsler, 1974). Children included in the study scored a minimum of 75 on the WISC-R, with an average IQ of 97.73. In

addition, the children were asked several questions about their perceptions of punishment and imagination using a 7-point scale.

The authors reported no significant correlation between sexually abused children and fantasy, imagination or dissociation in this sample (Rhue et al., 1995). This can be seen by looking at the similarity in scores of each group. They remarked that “sexual abuse that is not violent, severe, prolonged, or perpetrated by a mother or father may not have serious deleterious effects on the child or engender appreciable dissociative tendencies or a need to retreat from reality by way of fantasy” (p. 134). In this sample, for 8 of the 12 children “fondling was the most severe abuse that the child endured” (p. 134), and only 2 of the abusers had intercourse; only one third of the sample was abused by a parent or step-parent; and several were abused 1 to 3 times. They conjectured that the results may have been different if the abuse was more severe, prolonged, or more of the children had been abused by a parent or step-parent.

However, Rhue et al. (1995) did find that the physically abused children showed a higher association on the measures of increased fantasy, imagination, and dissociation. The results also supported a correlation between measures of dissociation and the childhood fantasy inventory ($r = .54$); dissociation and the fantasy proneness scale ($r = .39$); and a marginal correlation with the absorption scale ($r = .35$). The authors posited that since imagination and dissociation are related constructs, this study provides construct validation for the CPAS and measures of dissociation and fantasy.

The study by Rhue et al. (1995) had several limiting factors including the sample size and lack of a non-clinical control group. Furthermore, the methodology was not well explained, no citation was provided for the Childhood Fantasy Inventory, and no mention

was made about what they did with the human figure drawings. Its main contribution is that the sample consisted of children whose abuse was current rather than the retrospective report of an adult client.

There have been some reported cases that did not indicate a traumatic experience (Coons, 1996; Malenbaum & Russell, 1987). Coons (1996) compared three studies with a total of 100 participants and noted that “a complete lack of trauma in childhood was seen in only 5% to 8% of children and adolescents with either MPD or DDNOS” (p. 370). The role of trauma will be discussed further in the following sections on assessment and models and theories.

Other factors are also thought to relate to the development of dissociative disorders. Kluft (1984a) proposed a Four Factor Theory in which MPD develops in a person who has an innate capacity to dissociate (Factor 1); he experiences trauma, or “overwhelming life experiences during childhood” (p. 130), that leads to the use of dissociation as a defense (Factor 2); the dissociative defense becomes linked to intrapsychic structures that shape the formation of dissociated personalities (Factor 3); and the dissociation becomes fixed due to the absence of significant others to provide supportive and healing experiences or other buffers against further trauma (Factor 4). Factor 3 reflects research on the relationship between early trauma and dissociative identities, and Factor 4 is indicative of the importance of the attachment relationship. These factors will be addressed in more depth in the section on models and theories.

According to Wieland (2011), Kluft’s (1984a) first factor is more aptly described as a familial factor. In his article, Kluft presented two cases that included intergenerational MPD. In one of the cases he treated MPD in three generations. In both cases, Kluft

indicated that an alter of the MPD parent had abused the child. Kluft's case presentations led to other studies about the occurrence of dissociative disorders in multiple generations.

In a study of 18 patients, Braun (1985) found evidence to support his theory that MPD may have a transgenerational, or familial, association. He found evidence of MPD or dissociation in another family member in all 18 MPD patients. Twelve of the 18 cases were rated with a higher level of certainty, meaning that two other family members had consistently reported seeing symptoms, and there was documentation that a trained mental health professional had witnessed symptoms on at least one occasion. However, he acknowledged that this could not be clearly concluded from his data for several reasons: the study was done retrospectively; the sample was based on the availability of the family histories; and the information was not gathered systematically. Braun surmised that genetics and environment may play a role in fostering the development of transgenerational dissociation and recommended future studies explore these factors.

Coons (1985) conducted a study of the children of MPD patients. He matched a group of 20 MPD patients to a group of 20 patients with other diagnoses. There were no significant differences in the two groups regarding race, intelligence, education, or occupation. Eight of the MPD patients had children; ten patients in the control group had children. Nine out of 23 children of MPD parents had psychiatric diagnoses; two of the children had a dissociative disorder. In the control group, only one child out of 28 had a diagnosis of attention deficit disorder. Coons found the differences between these groups to be statistically significant ($\chi^2=7.81$; $p < .005$). Coons hypothesized several reasons for the higher incidence of psychiatric diagnoses in the children of MPD parents including

the severity of the parent's illness and continuing dissociation, psychiatric disorders in the other parent, absent fathers, poor parenting, and continuing abuse.

Malenbaum and Russell (1987) reported the case of an eleven-year old boy who was originally misdiagnosed. The correct diagnosis was made after finding out that his mother also had a history of MPD. The authors reported the etiology was speculative, but also noted elements in their case that supported MPD as a learned development based on the mother's reinforcement and facilitation of the child's symptoms. There was no known abuse or trauma in this child's history. This case is described in more detail in the Case Studies section.

Yeager and Lewis (1996) conducted a study to explore the family characteristics and symptomatology of children with a diagnosis of MPD or DDNOS. They screened 21 children under the age of 12 admitted to a dissociative disorders clinic. Eleven children qualified for the study based on a diagnosis of MPD or DDNOS and the availability of at least one family member to be evaluated. Five of the other children were diagnosed MPD or DDNOS, but family members were unwilling or unavailable for interviews.

The children were each seen for a minimum of four sessions: Seven of the children were seen for more than 10 interviews. Yeager and Lewis (1996) completed the evaluations for eight of the cases, and in the other three cases one of the authors worked with another psychiatrist. The authors also conducted interviews with parents and siblings. They reviewed any available records from psychiatrists, medical doctors, mental health professionals, schools, social services, family court, and protective services. Additionally, they examined samples of the children's drawings, schoolwork, diaries and journals completed before the evaluations to help confirm the diagnosis of MPD.

Children's reported histories of abuse were confirmed by records, family members, or physical examination. Some of the parents completed self-report measures of dissociative pathology for their children and themselves, the Child Dissociative Checklist (CDC; (Putnam, Helmers, & Trickett, 1993) and the Dissociative Experiences Scale (DES; Carlson & Putnam, 1993), respectively.

In order to receive a diagnosis of MPD, the child or family member had to meet the criteria in the DSM-IV (APA, 1994), and an evaluator had to witness a switch in personality state (Yeager & Lewis, 1996). If several dissociative symptoms were described by the family member or subject, including amnesia or personality changes, but an evaluator did not witness a change, the individual was given a diagnosis of DDNOS. Family members who reported dissociative symptoms that were not severe enough to be diagnosed MPD or DDNOS were simply noted to have dissociative symptoms.

This study reported results consistent with the literature on intergenerational MPD and DDNOS. Yeager and Lewis (1996) found that four siblings of subjects were diagnosed with MPD, three siblings were diagnosed DDNOS, and two other siblings had dissociative symptoms. Eighteen parents were interviewed, and 11 were diagnosed with dissociative symptoms: three mothers were diagnosed with MPD, one mother met the criteria for DDNOS, and the remaining parents had documented dissociative symptomatology. Remarkably, in each family, at least one other family member had a dissociative disorder in addition to the identified child.

Yeager and Lewis (1996) examined the abuse histories of the children and parents as well as violent relationships of the parents. They found a relationship between severe, physical and sexual abuse at an early age and the development of dissociative disorders.

They ascribed the continuation of dissociative responses as due to intergenerational violence; the parents had been abused physically or sexually by their parents, and they repeated the abuse on their children as well as choosing abusive partners. The authors reported it was not possible to determine whether there was any genetic tendency to dissociate or if the child was imitating the parents' dissociative behaviors.

Yeager and Lewis (1996) make several important observations about the nature and quality of the data obtained in studies to date. While recognizing that many of the studies are small and descriptive, they state:

This is not necessarily the fault of investigators, because these kinds of data are extremely difficult to obtain. The extraordinary chaos within these families often precludes evaluating even one parent, much less an entire family. Abusive parents tend to be secretive and, as stated, dissociative parents forget and distort. (p. 398).

Epidemiology of Dissociative Disorders

The prevalence of dissociative disorders in the general population of children is unknown (ISSD, 2004). Waller and Ross (1997) and Loewenstein (1994) have estimated the prevalence of dissociative disorders in the general adult population to range from 3% to 10%, respectively. Silberg (2000) cautions that these numbers cannot be assumed to extrapolate to the child population. She references a study by Putnam et al. (1996) that demonstrates that although the core symptoms of dissociation are the same across different ages, they have different age-related presentations. The symptoms also reflect more closely the adult presentation as the child ages, thus suggesting an evolution over time in the development of dissociative disorders. Silberg, Stipic, & Taghizadeh (1997) found the ratio of females to males with dissociative disorders varied from 1:1 for

children, to 9:1 for adults, which may also indicate that the two groups represent different populations. Silberg (2000) suggests that some children's dissociative symptoms may resolve normally through maturation, treatment, or a removal from pathological environments.

Hornstein and Tyson (1991) found 5% of the children admitted to an inpatient unit had dissociative disorders. Three percent of them were diagnosed with MPD. Silberg et al. (1997) found a similar prevalence rate with 5.2% of the children and adolescents admitted to another inpatient unit having dissociative disorders. No other prevalence studies have been done specifically for children.

Diagnosis of Dissociative Disorders

Silberg and Dallam (2009) state "the lack of consensus on diagnostic criteria is the greatest barrier to identifying dissociative pathology in children and adolescents" (p. 70). This section will discuss the past and present literature on diagnosing dissociative disorders. A discussion of the recurrent omission of criteria specific to children in the DSM is presented with a discussion of the early development of lists of diagnostic criteria in order to illustrate the progress and barriers that have been encountered; therefore, details of the various lists of diagnostic criteria are not provided. This historical review culminates in a more detailed discussion of the most recent developments for the assessment of dissociation, followed by a discussion of differential diagnosis. Finally, case studies of dissociative children will be reviewed to illustrate the range of symptoms and behaviors. A synthesis and analysis of the case studies will focus on how and when the diagnosis of a dissociative disorder was made.

Development of diagnostic criteria. Multiple Personality Disorder was first recognized in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III; APA, 1980). Its onset was described as beginning in early childhood or later. However, there was no mention made of diagnosing it in children. Peterson (1998) typified this lack of recognition of dissociative disorders in children when he noted the comments he heard from clinicians at a presentation in 1989, ‘I am working with a dissociative child but I can’t get the support of my child psychiatrist. When I bring up the idea of dissociative disorder in children, he says, “Show me where it is in DSM-III”’ (p. 7).

It appears there was a decline in interest in MPD in children after the first documented case in 1840 (Ellenberger, 1970; Fine, 1988). No further childhood cases were reported until 1984 when Kluft (1984a) described five case studies, and Fagan and McMahon (1984) described the diagnosis and treatment of four children. Kluft (1984a) reported the symptoms in the five cases he studied correlated with two unpublished predictor lists devised by himself (Kluft, 1978) and Putnam (1981): The lists were early attempts to identify symptoms or characteristics that would help to identify MPD in children. In this study, Kluft (1984a) noted that “childhood MPD was a *forme fruste* or attenuated expression of the adult variety...in the process of developing toward the classic form” (p. 124). He cautioned that although the study was significant, the data base was small and possibly not representative of the norm.

Fagan and McMahon (1984) used the term “incipient multiple personality” (p. 26) to describe symptoms found in a case study of 4 children; they believed these symptoms would predict the potential for developing MPD in adulthood. They created two lists, one

of 20 items that were observable by teachers and parents, and another of six subjective experiences reported by children. They acknowledged, again, the small number of cases studied, but attempted to compensate by also examining 13 other accounts that reported childhood experiences. They found that all of the manifestations were present in the 13 sources they investigated. They also reported that their lists were very similar to the list described by Putnam (1981).

Peterson (1990) published an article comparing the checklists to date by Fagan and McMahon (1984), Kluft (1978), and Putnam (1981). He combined the symptoms in the checklists into three categories. He then totaled the frequency of the symptoms in 21 reported case studies of childhood MPD. Peterson termed the manifestation of MPD in children “dissociation identity disorder” (p. 6). As a result of his analysis, Peterson proposed the first diagnostic criteria for dissociation identity disorder with the hope that it would be included in the next DSM revision.

Despite his efforts to influence the Work Group for the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV; APA, 1994) and changing the name to ‘Dissociative Disorder of Childhood (DDoC)’ (as cited in Peterson, 1998), the DSM-IV still did not include criterion for the diagnosis of children. Two advances were made, however, in that dissociative disorders were recognized in the rule-out criterion for ADHD, and children were recognized in the criteria for DID.

The struggle still continues to include a child-specific diagnosis in the DSM. The DSM-IV-TR (APA, 2000) did not include one, and it appears there is no movement to do so in the upcoming DSM-V (Spiegel et al., 2011).

In 2004 the International Society for the Study of Dissociation (ISSD), renamed the International Society for the Study of Trauma and Dissociation (ISSTD) in 2006, published *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents*. The Guidelines were written based on the clinical experience of the ISSD Child and Adolescent Task Force members, conference material, and published literature. The ISSD (2004) Guidelines were created to reflect a summary of current knowledge in the field. The ISSD Task Force recognized the continuing growth of knowledge in the field and intended the Guidelines “to be viewed as preliminary” (ISSD, 2004, p. 121). They are not meant to be prescriptive, but to be a useful resource to guide clinicians.

The Guidelines for assessment and treatment are based on symptoms because “there is still no real consensus about the typical case and thus no consensus about diagnostic criteria” (ISSD, 2004, p. 121). The ISSD (2004) Guidelines will be used to provide (a) a framework of components to be used in the general assessment of dissociation, (b) a guide for trauma assessment procedures, and (c) information to assess dissociative symptoms. The Guidelines were not designed to be used in the differential diagnosis of dissociative disorders and other disorders. For these reasons, the Guidelines will be supplemented with other relevant sources, and a discussion of differential diagnosis will follow.

Assessment components. The ISSD (2004) Guidelines suggest a framework of seven components to be used in diagnosing dissociative disorders in children: clinical interviews, comorbid conditions, medical evaluation, screening tests, structured clinical interviews, psychological testing, pharmacological and hypnotic interventions, and

ongoing assessment. The first three items are considered essential elements of any assessment for dissociative symptoms. An eighth item was excluded from this discussion as it applies to adolescents.

Clinical interviews. The initial assessment should include a clinical interview with the family, the child, and other relevant informants (ISSD, 2004). Special attention should be given to several factors. Dissociative symptoms are important to identify; they are described later in the symptom assessment section. The child's knowledge about dissociation, the family's understanding of and investment in dissociation, and a family history of dissociation are important aspects to assess.

A thorough assessment of the family environment is vital. It includes exploring any family history of mental illness, unusual beliefs or customs not due to the family's culture or ethnicity, emotional and physical safety of the family atmosphere, dysfunctional relational patterns, family secrets that may affect the child, and any support system other than the immediate family. Although the child may be experiencing dissociative symptoms due to past experiences, the symptoms are often perpetuated by a family's current system of dysfunction, and this needs to be investigated. Finally, the child's functioning at school, with peers, and in other settings should be assessed. Silberg (1998b) describes helpful interviewing strategies to use with children.

Comorbid conditions. Dissociative disorders often co-occur with other diagnoses including ADHD, depression and other mood disorders, ODD, PTSD, anxiety, obsessive-compulsive disorder (OCD), pervasive developmental disorder, reactive attachment disorder (RAD), and eating disorders (Hornstein, 1998; Hornstein & Tyson, 1991; ISSD, 2004; Peterson, 1998; Peterson & Putnam, 1994; Silberg, 1998b; Wieland, 2011).

Assessment is needed to determine if the child's symptoms are indicative of dissociation as a primary diagnosis or secondary to another disorder.

Medical evaluation. Dissociative disorders, especially DID and DDNOS, are poly-symptomatic and often mimic medical disorders (Graham, 1998; ISSD, 2004). A pediatric evaluation is necessary to rule out any medical basis for symptoms such as headaches, seizures, neurological disorders, and other somatic complaints.

Screening tests. There are no diagnostic assessments that can conclusively diagnose dissociative disorders. However, there are screening instruments that are helpful in alerting clinicians to the possibility of dissociative symptoms (ISSD, 2004). Those most pertinent to children include the Children's Perceptual Alteration Scale (CPAS; Evers-Szostak & Sanders, 1992), the Child Dissociative Checklist (CDC; Putnam et al., 1993), the Children's Dissociative Experience Scale and Posttraumatic Symptom Inventory (CDES; Stolbach, 1997), and the Adolescent Dissociative Experiences Scale (A-DES; Armstrong, Putnam, Carlson, Libero, & Smith, 1997). Two other instruments have been developed or adapted to include dissociation scales: the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), and the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005).

Children's Perceptual Alteration Scale. This scale was developed by Evers-Szostak and Sanders (1992) as a self-report measure for children ages 8 to 12 years-old. The 28 items of the CPAS are rated on a 4-point scale according to the frequency of the experience occurring, e.g., (1) the item never happens to them, to (4) the item happens to them almost always. Items were developed to reflect experiences of dissociation that

include imaginary playmates, loss of time, automatic experiences, heightened monitoring, loss of control over emotions and behaviors, and amnesia.

Evers-Szostak and Sanders (1992) reported the scale appeared to have validity and reliability in the initial study. The results also suggested that dissociation can be measured on a continuum, it presents normally in children, and the CPAS can be used to distinguish between pathological and normal levels of dissociation.

Importantly, the CPAS (Evers-Szostak & Sanders, 1992) appears to address some of the weaknesses of previous predictor lists (Fagan and McMahon, 1984; Kluft, 1984a). Whereas the earlier lists may be biased by definitions based on adult experiences and symptoms, the experiences and definitions used in the CPAS were designed specifically for children. The CPAS addresses experiences that were missing from the previous lists: “The earlier checklists categorize mood, but not affect; fluctuation in behavior, but not changes in control; and third person quality, but not changes in self-monitoring” (Evers-Szostak & Sanders, 1992, p. 94).

Mann and Sanders (1994) presented results that further supported the validity of the CPAS (Evers-Szostak & Sanders, 1992). In a study of 40 boys and their parents, they found a correlation between dissociation and attention problems that may support the notion that dissociative symptoms may outwardly present as symptoms of ADHD (Peterson, 1990; Putnam, 1991). They also found the CPAS correlated with parental inconsistency and rejection.

As discussed earlier Rhue et al. (1995) studied the correlation between fantasy, imagination and dissociation in 9 physically, 12 sexually, and 18 non-abused children.

Their findings provided support for the construct validity of the CPAS and a correlation between measures of dissociation and fantasy.

Child Dissociative Checklist. The CDC (Putnam et al., 1993) is a screening tool for dissociative disorders in children ages 5 – 12 years. It is a 20-item report form that is completed by the caregiver or other observers familiar with the child. The observer is asked to rate dissociative behaviors observed in the last 12 months on a 3-point scale: 0 = not true, 1 = sometimes true, 2 = very true. Dissociative behaviors are assessed in six domains: (a) aggressive and sexual behavior, (b) dissociative amnesias, (c) spontaneous trance states, (d) rapid changes in demeanor, knowledge, age-appropriate behaviors, and abilities, (e) hallucinations, and (f) identity alterations. A score of 12 or higher is indicative of pathological dissociation. The CDC has been shown to have good reliability and validity (Hornstein & Putnam, 1992; Putnam et al., 1993; Putnam & Peterson, 1994). It is the most widely used screening instrument (Silberg, 2009).

Children's Dissociative Experience Scale and Posttraumatic Symptom Inventory. The CDES (Stolbach, 1997) is a 37-item self-report measure used to assess posttraumatic symptoms and dissociative experiences in children ages 7-12 years-old. Initial results indicate it has good reliability and validity.

Adolescent Dissociative Experiences Scale. The ADE-S (Armstrong et al., 1997) is a 30-item self-report instrument designed for adolescents ages 11-18. However, it has been used in a validation study with children as young as 10 years-old (Kisiel & Lyons, 2001). The ADE-S measures four dissociative domains: (a) dissociative amnesia, (b) passive influence, (c) absorption and imaginative involvement, and (d) depersonalization and derealization. Items are rated on an 11-point scale from 0-10, with 0 being “never”,

and 10 being “always” (p. 3). Several studies have found the ADE-S to have high split-half reliability coefficients, test-retest reliability, and high Cronbach alpha coefficients (Armstrong et al., 1997; Brunner, Parzer, Schuld, & Resch, 2000; Farrington, Waller, Smerden, & Faupel, 2001; Kisiel & Lyons, 2001; Muris, Merckelbach, & Peeters, 2003; Prohl, Resch, Parzer, & Brunner, 2001; Smith & Carlson, 1996; Zoroglu, Sar, Tuzun, Tutkun, & Savas, 2002). The A-DES is scored by adding the circled scores from each item and dividing by 30. Scores range from 0 – 10. Score above 4 typically indicate significant levels of dissociation (Putnam, 1997).

Trauma Symptom Checklist for Children. The TSCC (Briere, 1996) is used with children ages 8 to 16 to evaluate symptoms of trauma. It is a self-report measure with 54 items. It has six scales including depression, anxiety, anger, dissociation, posttraumatic stress, and sexual concerns. An alternative version, the TSCC-A, which excludes the sexual concerns is also available. It has been shown to have good reliability and validity (Strand, Sarmiento, & Pasquale, 2005).

Trauma Symptom Checklist for Young Children. The TSCYC (Briere, 2005) was created for use with children ages 3 to 12. This 90-item report is completed by a caretaker to assess trauma-related symptoms. The TSCYC has two scales to assess the validity of caretaker reports and eight clinical scales: (a) posttraumatic stress – avoidance, (b) posttraumatic stress – intrusion, (c) posttraumatic stress – arousal, (d) posttraumatic stress – total, (e) dissociation, (f) anxiety, (g) anger/aggression, and (h) sexual concerns. Studies using the TSCYC have indicated reliability and validity (Briere et al., 2001; Lanktree et al., 2008).

Psychological testing. The ISSD (2004) Guidelines indicate that psychological testing “is not diagnostic, but may be corroborative” (p. 126). Psychological testing results are given considerable weight in determining a child’s eligibility for services, school accommodations, and treatment (Silberg, 1998a).

In a preliminary study, Silberg (1998a) administered psychological tests to 30 children diagnosed with DDNOS or DID and a control group of 30 children. Technicians blind to the diagnosis were able to discriminate 93% of the dissociative sample from other patients with no dissociative diagnosis based on test behaviors and responses. This study demonstrates that psychological testing may promote the early diagnosis of dissociative disorders. One limitation is that participants ranged in age from 6-17 years. So although Silberg (1998a) uses the term ‘children’, it is possible there may be a difference between children and adolescent scores that was not evaluated.

Pharmacological and hypnotic interventions. The ISSD (2004) Guidelines discourage the use of pharmacological interventions in assessing children. Hypnosis has been used in diagnosing dissociative disorders in children (Benjamin & Benjamin, 1993; Williams & Velazquez, 1996). However, there are legal issues pertaining to hypnosis in the United States and possibly other jurisdictions: clinicians must obtain explicit permission from the legal guardian; and risks involved must be disclosed, including the possible restriction of hypnotic information in legal proceedings (ISSD, 2004). Therefore, the Guidelines recommend hypnosis be used only in cases of “severely unresponsive children where other methods have been ineffective” (ISSD, 2004, p. 127).

Ongoing assessment. The Guidelines (ISSD, 2004) recommend assessment be a continual aspect of treatment with a focus on the most effective way to ameliorate

disruptive behavior. Dissociative symptoms should be assessed frequently to measure progress. The corroboration of all treatment professionals is encouraged (Hornstein 1998; ISSD, 2004; Nemzer, 1998). The Guidelines advise that conflicts among professionals regarding diagnosis may mirror dynamics within the child or family; an understanding of this parallel process may advance “integrative problem solving for the team, the family, and the child” (ISSD, 2004, p. 127).

Trauma assessment. Because trauma is so highly correlated to dissociative disorders (Chu & Dill, 1990; Greaves, 1980; Putnam et al, 1986; Ross et al., 1990, Stern, 1984), it is imperative to conduct an exhaustive trauma assessment. The Guidelines (ISSD, 2004) describe several scenarios of children presenting for evaluation. Some children will present with a clear history and documentation of trauma and dissociative symptoms at the initial assessment. Some children may present with a history of a traumatic event, but not have dissociative symptoms. Other children will present with no known history of trauma, but still exhibit dissociative symptoms. Therapists are cautioned that dissociative symptoms are not evidence of trauma in and of themselves. Sometimes trauma histories are disclosed in later sessions or may be unknown due to the child’s amnesia.

Suggested items to assess for in the child’s history include: physical, emotional or sexual abuse; neglect and poor attachment; witnessing violence; loss of parent through death or separation; other experiences involving death or illnesses; and peer rejections. Clinicians are advised not to use suggestive questions (Silberg, 1998b). While clinicians should be alert to children or families providing inaccurate, manipulative, or distorted information, they are also advised not to automatically discount reports of traumatic

events that appear improbable or bizarre because they may have happened (Everson, 1997). Because children may not have verbal memories of traumatic experiences, clinicians should be familiar with the use of expressive therapies for assessment and understand how past traumas may be communicated through somatic symptoms (ISSD, 2004).

Symptoms assessment. The ISSD Task Force on Child and Adolescents developed a description of symptoms of dissociation based on past research and the most current clinical knowledge (ISSD, 2004). The Guidelines classify the symptoms as trance states, amnesia and transient forgetting, imaginary playmates, identity alteration and state changes, changes in affect and behavior, somatic symptoms, posttraumatic symptoms, sexually reactive or offending behaviors in children, depersonalization, derealization, and self-injurious behavior.

Trance states. Trance states may range from momentary lapses of attention that occur normally in children to more extensive periods of non-responsiveness, to inordinate sleeping or fainting (ISSD, 2004), and in the extreme, to coma states (Cagiada et al., 1997). Wieland (2011) describes trance states as a “blank stare or ‘empty’ eyes” (p. 8). Silberg (1998b) reports that children in trance states may close their eyes briefly, stare straight ahead, or “engage in repetitive movements while looking distracted” (p. 57).

Amnesia and transient forgetting. Dissociative amnesia in children is often described as lying by caregivers (Silberg and Dallam, 2009). Amnesia for recent behavior is considered rare and is indicative of a more severe dissociative disorder. Amnesia usually is found for past traumatic events. Transient forgetting occurs when children state they are unable to remember an event. Often they say “I forget” to avoid responding,

possibly due to guilt, shame, or lack of rapport with the clinician. They are usually able to remember when working with an “empathic therapist” (ISSD, 2004, p. 130).

Imaginary playmates. It is difficult to differentiate imaginary playmates and fantasy play from dissociative symptoms because these are developmentally normal behaviors for young children (Hornstein, 1998; Kluft, 1984a; Peterson, 1991; Silberg, 1998b; Waters, 2005). Pathological dissociation is indicated when a child believes their imaginary playmate is real, when the imaginary playmate is in conflict with the child or another imaginary figure, when the child identifies the imaginary playmate as controlling the child’s behavior, and when the child’s fantasy play interferes with normal functioning (Silberg, 1998b; Trujillo, Lewis, Yeager, & Gidlow, 1996; Waters, 2005).

Identity alteration and state changes. Some children experience the presence of other personalities also known as ego states, internal others, self-states, and alters (ISSD, 2004). Changes in younger children are often very subtle, and “switches” in personality may go unnoticed (Hornstein, 1998; Wieland, 2011).

Changes in affect and behavior. Changes in a child’s affect and behavior indicative of dissociation include a sudden regression in age, use of third person references to self, use of a different name, loss of consciousness, and rageful behavior (ISSD, 2004). Wieland (2011) further describes changes in affect and behavior to include changes in age progression, changes in abilities, changes in likes and dislikes, changes in voice, changes in demeanor, and changes in emotion that are out of context with the situation.

Somatic symptoms. Symptoms for which there is no medical explanation may include stomachaches, headaches, or other bodily pain. Somatoform dissociation may be

indicated by enuresis or encopresis, a loss of bodily sensation, and unusual tolerance for pain or awareness of pain (ISSD, 2004; Wieland, 2011).

Posttraumatic symptoms. Dissociative symptoms may also include post-traumatic symptoms such as avoidance and numbing, intrusive thoughts and memories, nightmares, flashbacks, traumatic re-enactments, and hypnagogic hallucinations (ISSD, 2004).

Sexually reactive or offending behaviors. Sexually reactive or offending behaviors are present in traumatized children and may also occur as part of dissociative symptomatology (ISSD, 2004).

Depersonalization and derealization. Depersonalization occurs when a child reports that a situation happened to someone else, or that the child observed it happening as if the child was outside of himself. Derealization occurs when a child feels like the event is not really occurring.

Self-injurious behaviors. Physical injuries can be intentional or accidental (Shirar, 1996). Dissociative children who are depressed or suicidal may engage in head banging, cutting, scratching, or burning. Episodes of anger may lead to extreme risk-taking behaviors that result in accidental injuries. Dissociative children may have no memory of the behavior later, or may be numb to the physical sensation (ISSD, 2004; Shirar, 1996).

Differential diagnosis. After the initial interview with the child and caregiver in which current symptoms have been observed or reported, the next step is “to proceed with a differential diagnosis to determine (a) what is the primary diagnosis, and (b) if a dissociative disorder is either a primary or co-morbid diagnosis, what is the most accurate diagnosis” (Hornstein, 1998, p. 37). When a dissociative disorder is suspected, children

are more often diagnosed DDNOS (Putnam, Hornstein, & Peterson, 1996). Hornstein recommends involving the whole treatment team or consulting with other professionals in this process. This process may include using screening tools to rule out other diagnoses and medical examinations to rule out any organic basis for symptoms. The purpose of differential diagnosis is to find the diagnosis that best explains the symptoms. When comorbid diagnoses are present, it is preferable to use the fewest diagnoses possible.

Dissociative children are poly-symptomatic, and their symptoms are often identical to those of other diagnostic classifications (Hornstein, 1993, 1998). As previously noted, the literature indicates that children are frequently misdiagnosed with other disorders including ADHD, anxiety, depression and other affective disorders, PTSD, conduct disorder, ODD, conversion and somatoform disorders, schizophrenia, BPD, and epilepsy (Hornstein, 1993, 1998; Nemzer, 1998; Peterson, 1998; Zoroglu, et al., 1996). Peterson (1998) argues that it is because clinicians are not asking the right questions about symptoms. “Considering the old medical aphorism ‘if you hear hoof beats think of horses, not zebras,’ for those in child and adolescent psychiatry, psychology, and social work, the ‘horses’ are attention-deficit/hyperactivity disorder, conduct disorder, and major depression – but decidedly *not* dissociative identity disorder” (Peterson, 1998, p.6). Although the literature indicates that clinicians have a “low index of suspicion” for DID (Hornstein, 1993, p. 137), Nezmer (1998) states a “high index of suspicion” is essential (p. 240). She stresses the importance of assessing every child for DID regardless of the presenting problem.

Differential diagnosis is made difficult due to the continued lack of recognition of dissociative disorders by other professionals. Peterson (1998) made several attempts to

gain recognition of dissociative disorders in children. He influenced the inclusion of dissociative disorders in the differential diagnosis for ADHD in the DSM-IV (APA, 1994). However, no other advancement has been made to include dissociative disorders in the differential diagnoses of any other disorders in the most recent revision, the DSM-IV-TR (APA, 2000). He also approached the authors of the “Practice Parameters for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder” (Peterson, 1998, p. 20) to encourage them to include information on dissociative disorders. Via a personal communication, McClellan and Werry, the authors, told him “they could find very little information on dissociative disorders in youth, so they did not have the facts they needed to evaluate what they should include in dissociative disorders” (as cited in Peterson, 1998, p. 20). Although he provided them a packet of information, and they assured him they would include the information in the guidelines, the most recent Parameters for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder (American Academy of Child and Adolescent Psychiatry [AACAP], 2007) still do not mention dissociation.

Graham (1998), Hornstein (1998), Nemzer (1998), and Peterson (1998) have all written book chapters about the differential diagnosis of dissociative disorders from other disorders with similar symptoms. Clinicians need to have a clear understanding of the presentation of symptoms. This occurs through trial and error, knowledge gained from the literature, and experience (Silberg, 1998b).

Treatment Research: Case Studies

Research on the treatment of dissociative disorders is scarce, and the available research is primarily in the form of case studies. Therefore, case studies of children under

the age of twelve were chosen to be reviewed for information pertaining to the presentation of dissociation and the diagnostic process. Although Kluft (1984) presented five cases, four of which were children under 12, they are not included in this review because they did not provide descriptions of the diagnostic process.

Fagan and McMahon (1984). Fagan and McMahon (1984) discussed the treatment of four cases; however, one of the cases was an adolescent. Therefore, only three cases are examined here. It was noted that McMahon was the clinician and made the diagnosis for each case.

In the first case, the authors reported using “a variety of play therapy procedures” (p. 27) with two adopted sisters, ages 6 and 4, and behavioral strategies with the adoptive parents. The girls were brought to therapy by their adoptive mother after she found them masturbating each other during their bath. The authors gave scarce details about the treatment in the first two months. At this time, the caseworker discovered that the girls had been sexually abused, and they were formally diagnosed with “incipient multiple personality” (p. 29), the term used by Fagan and McMahon to denote the potential development of DID in children. At the next session, the girls were given dolls. They were told that the dolls were “children who had been hurt and helpless and needed love” (p. 27). The therapist showed them how to use clay to make male dolls. The male dolls were then used to simulate sexual abuse on the female dolls. Both children reacted intensely and beat the male dolls to pieces. This abreaction experience enabled the girls to remember episodes of abuse and to talk about them.

In the second case Fagan and McMahon (1984) described an 8 year old girl who was referred for behavioral problems. During testing, the child revealed that she was

“really two people” (p. 27). She received play therapy biweekly for two months. The authors report using dolls to role play and explore the personalities. They used the metaphor of meeting at a wall (as cited in Smith, 1981) to bring the two personalities together.

The third case involved a boy, age 4 years, who was treated in the hospital. Fagan and McMahon (1984) stated he was found next to his mother, who had been murdered, along with his older sister. The boy’s throat had been slit. He had no memory of the incident, but got a vacant look when he saw scissors or a knife on the tray. He was treated using three sessions of play therapy. He was given dolls to “provide identification for him and as objects for release of hostility” (p. 28). He had an abreaction after two weeks in which he expressed outrage and destroyed the doll representing the aggressor. He then expressed terror and began screaming. He calmed down afterwards and no longer responded with a dazed look when he saw the scissors or the knives.

Malenbaum and Russell (1987). Malenbaum and Russell (1987) presented the case of an 11-year old boy, Jesse, whose history included auditory hallucinations for five years with voices telling him to hurt himself, robbery, an imaginary friend when he was 3 to 5 years old, aggressive behavior, loneliness, sadness, disrupted sleep, and suicidal ideations. Malenbaum and Russell were both involved with the diagnosis and treatment of Jesse after he was admitted to the children’s inpatient unit of the hospital they worked at. A diagnosis of major depression was considered, however, Jesse’s mood improved significantly after admission to an inpatient facility. He was given a diagnosis of schizophrenia as the hallucinations continued. However, he displayed no indication of a formal thought disorder and did not present with any flat, blunted, or inappropriate affect.

Various medications were tried: Mellaril and Haldol had marked negative side effects; Lithium increased his aggressiveness; Inderal decreased his aggressiveness to some degree. However, none of the medications had any effect on the hallucinations. A diagnosis of MPD may have been over-looked had his mother not disclosed that she also had a history of hearing voices from the age of 3 or 4 when she experienced the trauma of her biological father leaving and her stepfather abusing her sexually. Upon further evaluation, Jesse described three alters. This case exemplifies the difficulty of differential diagnosis, the possibility of a generational aspect of MPD, and the differences in symptomatology in adults and children. Treatment was not completed as Jesse was transferred for long-term care soon after the diagnosis was made.

Riley and Mead (1988). One of the youngest cases of MPD treated was described by Riley and Mead (1988). Riley was the treating clinician in this case, and he was able to observe the development of MPD in a child named Cindy. The author's first encounter with Cindy was when she was 14 months old due to a custody evaluation. At this time she was a happy child with a secure attachment to her guardian parents. The biological mother was granted visitation in the guardian's home.

Riley and Mead (1988) reported that even though Cindy displayed symptoms of anxiety, decreased appetite, anger outbursts, and poor sleep at a session when she was 16 months, the court granted the biological mother custody. A schedule was implemented to make the transition. At 20 months, Cindy began having visitations with her biological mother outside of the guardian parents' home. At 23 months, Cindy appeared anxious. She reportedly clung to her guardian mother and begged to have no more visits. More changes were noted over the next few months. Cindy became withdrawn, clingy, and

frequently ill. She reported her genitals being touched by her half brothers and physical abuse.

Riley and Mead (1988) reported overnight visits were ended when she was 30 months old due to these reports. However, symptoms of anger, tantrums, and clinginess persisted. Cindy still reported sexual and physical abuse after day visits and began acting out sexually with her younger adopted sister. She woke frequently at night and would repeat her name in her sleep. When the guardian mother made a surprise visit to the biological mother's home, Cindy appeared to not know her. At 35 months old, one of the authors videotaped four sessions that demonstrated changes in the personality of Cindy. Visitation was ended and treatment began.

The authors reported using non-directive play therapy for 12 sessions (Riley & Mead, 1988). The child's guardian mother attended the sessions and the therapist provided interpretations to her. The child's adopted sister participated in three of the sessions. The child played out themes of anger, fear of her biological mother, protection and danger, and changing scared and sad little girls into happy ones. The authors also implemented an integrative intervention in which they played back the videotape so the client could see herself; this helped to point out to her that although she seemed to be a "separate" person on the television, she really was not. The authors report therapy was terminated after four months, and a follow-up session conducted in the home nine months later found her doing well.

Albini and Pease (1989). Albini and Pease (1989) discussed the treatment of two cases of preschool-aged children with dissociative symptoms that they believed to be precursors to MPD. It is not specifically stated who made the diagnosis in these cases.

However, since Albini was in private practice at the time while Pease was a doctoral candidate at Cornell University and a professor at Governors State University, it may be assumed that Albini was the treating clinician. The authors report that both children had experienced the trauma of abuse in their first two years, and initiated treatment at ages 2 years, 9 months and 2 years, respectively.

In the first case of a 4 year old girl named Pam, the authors reported she would paint her face and stand “in front of a mirror to deny that she was herself” (p.146). They also described other instances as examples of the child beginning to form alter personalities: (a) in one incident, she denied being Pam while cutting identical pieces of play dough; (b) in another incident, an adult neighbor saw a distinct change in her demeanor, and (c) in a third instance, the therapist witnessed her change to a “scary bear” (p. 146) who only responded when the therapist addressed the child within the bear. In the second case of a 4 year old boy, the authors reported he had trance-like states, amnesia for nighttime awakenings, and fugue-like periods.

The authors indicated they used play therapy in both cases, however, no specifics were given other than that the girl began therapy throwing a variety of toys out the window, progressed to throwing a doll back and forth, and in later sessions painted the face of the therapist and foster mother along with her own (Albini & Pease, 1989). She appeared to be playing out themes of mastery and nurturing. The authors indicated that the boy had a fear of broken toys, play dough, and “phallic toys” (p. 146).

The length of treatment for Pam was not given. The treatment for the second child was reportedly 3 years, and the authors stated he achieved cohesion. Albini and Pease (1989) indicated that the second child had a more favorable outcome. Differentiating

factors appeared to be that in the first case, retraumatization was experienced due to continuing re-exposure to the abuser, whereas, in the second case, the child was removed from the abusive environment, the mother was in attunement with him, and treatment was initiated sooner. It is also notable that the second child had a family history of “DISS/MPD” (dissociation/multiple personality disorder; Albini & Pease, 1989, p. 146).

LaPorta (1992). LaPorta (1992) reported the case study of a 9-year-old girl, Jane. She held this case up as an example of the difficulties clinicians have in diagnosing MPD. Jane’s mother had initiated treatment citing behavioral problems including aggression, lying, destructiveness, cruelty to animals, stealing, and affectionate behaviors and clinging toward strangers. Her mother reported she had many food allergies; she stated foods such as proteins and sweets resulted in symptoms of hyperactivity, seizures, irritability, enuresis, mood swings, and contrary behaviors. Her mother and adoptive father reported that she overate, and they locked her in her room to keep her from eating in the middle of the night.

However, school personnel reported Jane to be underfed and did not note any of the behaviors described by the parents. They made a report to protective services when Jane came to school with a bruise on her face inflicted by her stepfather. Protective services had made two prior investigations of possible sexual abuse when Jane was two and a half and four years old. Jane had a history of recurring urinary tract infections, febrile seizures, and ear infections. According to the growth charts, Jane had not gained any weight since she was 4 years old. Jane was removed from the home and placed in shelter care. Notably, Jane’s parents “abruptly decided to give her up for adoption” (LaPorta, 1992, p.616).

It is not clear how much time lapsed, but LaPorta (1992) reported treatment began after Jane entered shelter care. She was first diagnosed with reactive attachment disorder. LaPorta reported that Jane repeated phrases in a trance-like state during play, displayed amnesia about sessions, and that she often referred to the “Bad Big Sister” (p. 617). LaPorta was able to distinguish the “Bad Big Sister” as an alter rather than an imaginary friend based on her knowledge of the literature (Baum, 1978) that shows children may speak of their friend as a separate person, but they do not pretend to become their imaginary friend or propose that it is possible.

According to LaPorta (1992), Jane was treated using play therapy along with storytelling and bibliotherapy interventions. Themes of starvation, sexual abuse, hostility, and aggression indicating trauma were revealed through her play. The author specifically described Jane “pretending to prepare and eat food” (p.617) and using doll play.

The time frame for treatment in this case is unclear. The abstract for this article noted that diagnosis occurred over a period of six months (LaPorta, 1992). The author provided an update on progress at 7 months, however, it is uncertain whether the diagnosis period is included in this time frame. The author then stated that Jane’s personalities appeared to be integrated, and she had no dissociative symptoms “at the end of 4-month follow-up on a weekly basis” (pp. 617-618). It appears that treatment could have lasted anywhere from twelve to eighteen months.

Snow, White, Pilkington, and Beckman (1995). Snow, White, Pilkington, and Beckman (1995) presented another case in which a 4-year old girl was diagnosed with DID through play therapy. It is not indicated which author may have been the treating clinician in the case. Some of the symptoms noted include the use of another name,

nightmares, changing behaviors, ear aches while sleeping, and amnesia for an event that occurred in the playroom. A traumatic history may be inferred as it was reported that when she was two, her father had come home and found her crying while her mother packed her things to leave. The child witnessed the interchange between the parents as the father attempted to talk to the mother. Later, the child disclosed sexual abuse in a play session.

It is difficult to ascertain the type of play therapy used. The child reportedly played with sand, water, and pillows. It appears that it was at times non-directive. The therapist appeared to make attempts to expand the meaning through comments such as “it sounds like you have to eat things that you don’t like” (Snow et al., 1995, p. 121). The therapist also set limits, e.g. “I’m not for hitting” (p. 121). However, contrary to child-centered play therapy (Landreth, 2002), the therapist did ask questions. The therapist met with the parent and child individually and together. Treatment was terminated prematurely due to the father being hospitalized for depression. Interestingly, he was diagnosed with MPD during this hospitalization.

Cagiada, Canidio, and Pennati (1997). Cagiada, Canidio, and Pennati (1997) reported a team approach was used in diagnosing and treating an 11-year old boy, Basile, who entered a psychogenic coma after enduring trauma. He had been taken from his home in Africa by guerilla soldiers. He witnessed a friend killed by the soldiers, and he was threatened with death and harm until a ransom was paid and he was released. The authors reported the boy had several posttraumatic symptoms, “experienced a total psychic detachment from his body (a state of profound depersonalization [Spiegel,

1991]), and was separated from his environment by strong dissociative defenses” (p. 183). Nineteen months passed before proper diagnosis was made and treatment began.

Basile was treated over the next six month period using psychopharmacology, hypnosis three times a week along with hypnotic metaphors, gradual exposure, and a computer with a graphics program (Cagiada et al., 1997). The authors reported using age regression, abreactive techniques, and story changes. Visual-kinesthetic dissociation via the use of a computer provided a means of protection as it would allow him “to communicate without being overwhelmed by fully re-experiencing past traumata” (p.184). The child used the computer to draw pictures of his experiences. As his treatment progressed, he began to draw and write on paper. During this time, his mother and other family members received psychotherapeutic support. The authors stressed that the success of this case was not based on a single modality or professional, but on the committed effort of the team and the combination of psychotherapy involving hypnosis and psychopharmacological treatment.

Baita (2011). Baita (2011) described the first case of dissociation she worked with in 1998 in Argentina. Dalma, a 4-year old female, was referred to her due to alleged sexual abuse by her father. Dalma’s mother had a history of being sexually abused by her brothers and emotionally and physically abused by her parents. Her father was unemployed. He reportedly fought with his employers as well as his neighbors. He kept the children isolated from the other children where they lived. He was physically abusive to Dalma’s brother, but “would spend lots of time playing and taking naps with her” (p. 32). Each child in the family had an official name on documents and another name that

they were called in the home – a common practice in Argentina. Dalma's second name was Debora. She is the only child who was called by both names.

Baita (2011) stated that Dalma's foster family reported regressive behaviors, forgetfulness of activities, and trance-like states. In her initial assessment, Baita noted that Dalma had "alterations in consciousness and memory" (p. 33). For example, she was unable to remember her father's name, and she demonstrated trance-like staring, unresponsiveness, and contradictions in her stated reality with the actual reality. Baita asked Dalma to do human figure drawings as part of her first assessment; she reported the drawings looked like robots "with things coming out of the head" (p. 33). In another assessment session, Baita (2011) asked if Debora knew anything about what happened with Daddy. This action helped to emphasize the importance of using terminology the child knows. The child used dolls and repeatedly demonstrated the sexual abuse.

Dalma was in treatment weekly for 3 years (Baita, 2011). Although treatment of dissociative disorders has been described by trauma professionals as occurring in 3 stages – stabilization and safety, symptom reduction and trauma processing, and resolution and integration of traumatic memories (Van der Hart, Nijenhuis, and Steele, 2006), Baita depicted the treatment in three phases that corresponded to the involvement and contact of the child's mother in her life. Phase one lasted approximately one year. During this time Dalma had no contact with her mother. Baita discussed the use of the following interventions during this period: reassurance of safety; mapping the system using drawings, toys, or other creative means to identify other parts; the use of containment techniques to keep parts safe such as using boxes, visualization or drawings; and psychoeducation about dissociation with the child and other significant people (e.g.,

family members, foster care workers, teachers). She stated that Dalma did not allow her to participate in her play. Therefore, her “interventions were limited to making links and connections between play material and the things we knew had happened in her real world” (p.48).

Phase two consisted of family therapy with Dalma, her mother, and three siblings who had also been abused by the father. Baita (2011) reported the purpose of the sessions was to allow the children to ask questions regarding the situation that led to their removal from the home and to assess the mother’s ability to protect them in the future. Baita and the mother’s therapist conducted the family therapy sessions together for the first three months. Then the other therapist stopped coming. Baita also continued having individual sessions with Dalma after the family session. During this time, Baita reports the mother continued to be inconsistent, unpredictable, and emotionally unavailable to the children. She discussed the impact of these sessions on Dalma in terms of safety and attachment: Dalma’s defense was to dissociate. After eight months, Baita ended the family sessions.

Baita (2011) reported that the children had been retraumatized after the last family session when the mother asked them if the abuse was true. “Within a couple of weeks after suspending the family therapy, crazy, wild children came for their individual sessions....Dalma was acting again in a bizarre, sexualized manner...as she had during the first part of therapy” (p. 58). Baita met with the mother and ascertained that she was unable to understand her children’s responses to the question. Her inability to believe the abuse occurred was a significant risk factor for future emotional and sexual victimization of her children.

In phase three Baita (2011) continued to have individual sessions with Dalma while she continued to have sporadic unsupervised visits with her mother. During this time Baita primarily discussed the use of the Inside – Outside Technique: the child draws a picture of “his or her outside head and his or her inside head” (p. 61). Baita reported she uses this technique for assessment and throughout treatment. She also reported play with dolls.

Baita (2011) reported that treatment was ended prematurely due to the “financial situation in Argentina” (p. 67). However, she stated that Dalma’s play had begun to be more structured and organized. She was able to make comments and ask questions of Dalma without her dissociating or becoming anxious.

Grimminck (2011). Grimminck (2011) presented a case study of her treatment of a 6-year-old female named Emma. Emma was sexually abused by her father and paternal grandfather as an infant. The abuse was continued by both men during weekend visitations after her parents divorced. The author identified an insecure attachment between the child and her mother who was diagnosed with borderline personality disorder. Therefore, she facilitated a secure attachment to herself to help rewire the child’s brain to reduce the need for dissociation (p. 77). Grimminck described symptoms of dissociation including trance-like staring, amnesia, changes in facial expressions that she later determined indicated switching, variations in performance and memory, and denial of behaviors.

Emma had previously received play therapy for three years due to “physical problems and behavior diagnosed as conduct disorder” (Grimminck, 2011, p. 80). The previous therapy had little effect most likely because the abuse was still occurring, and

the dissociation was not addressed. The child was diagnosed with schizophrenia and referred for inpatient treatment.

Grimminck (2011) had some training in treating dissociation in adults. She adapted the instruction she received in her work with Emma. She had individual sessions with Emma once per week and a session with her mother once each month. Grimminck emphasized the importance of establishing a “safe environment in therapy” (p. 81) and consistency in keeping appointments. She appeared to follow the three stage model that begins treatment with symptom reduction and stabilization, then addresses traumatic memories, and results in the integration of parts (Van der Hart et al., 2006; Herman, 1992).

Grimminck (2011) reported using a variety of methods in treatment including hypnotherapy, role playing, painting, drawing, bibliotherapy, clay, and play. She used hypnotherapy to help reduce Emma’s fear, increase relaxation, improve sleep, and change dreams. She reported that hypnotic suggestions also were helpful in preventing flashbacks and reducing sexual behaviors. They used dolls to role play appropriate sexual behaviors. Emma used painting and drawing to “tell” about the abuse because, although she was forbidden to speak about it to anyone, she was not prohibited from drawing. Grimminck described using a “Big Book of Secrets, where children could put pictures and stories about memories until they felt ready to work on them” (p. 88). Another book, called a “Second Stage Book” (p. 88) lets children share their pictures and stories with each other to help reduce feelings of loneliness and stigmatization. Another intervention Grimminck used was to make “an imaginary photo album with old pictures that we

closed and put in an imaginary vault” (p. 88). Emma could open it, look at the pictures, and close it whenever she wanted to. Bibliotherapy was used to discuss sexual education.

Grimminck (2011) pointed out that Emma’s parts were named after behaviors, feelings, or imaginary names. Her treatment of them concurred with Silberg (1998c) in that she accepted them, listened to them, and helped to work through the trauma they originated from. In one instance, she thanked the part and told her “she could go to the safe place where her friends, the other helper parts, were” (p. 90).

Marks (2011). Marks (2011) provided an intensive treatment over a two-week period with a seven year old boy named Jason. Jason’s adoptive mother brought him due to highly aggressive, defiant, and controlling behaviors. She reported he raged for hours, broke objects, and hurt her. At other times, he appeared to regress in age and presented with infantile behaviors. He had received therapy for these behaviors to no avail.

Marks (2011) conducted the initial assessment without knowledge of any background information. Her assessment is a semistructured interview using projective techniques to learn about the child’s experiences with family, school, and friends. Some of the techniques include projective pictures, projective play, drawings, and story completions. During the two-hour assessment, Marks observed Jason exhibiting controlling and regressive behaviors; trance-like states; and amnesia for his birth family, other previous placements, and his adoptive mother’s name. Jason’s responses to the projective pictures and his projective play with the dollhouse indicated past abuse and neglect. The Child Dissociative Checklist (CDC) completed by the adoptive mother indicated a high degree of dissociation.

Marks (2011) decided to do the intensive therapy for two reasons: First, Jason lived far away, and it was not possible to bring him weekly, and secondly, she believed it would be more helpful as it was likely that Jason would become highly volatile as they began to work with the dissociation and the trauma. “For some children, when dissociation is first addressed, the extreme behaviors can intensify. This may be the internal self-states reacting to being recognized....” (p. 99).

Marks (2011) included the adoptive mother in the sessions and had a colleague present to assist her. Her colleague performed Eye Movement Desensitization Reprocessing (EMDR) with Jason to help process the trauma and create positive experiences. The author reports that she and her colleague also both participated in psychodramas and other interventions. Marks had an individual session with the mother at the beginning of each day, and her colleague had a session with Jason to assess where they were emotionally and psychologically. This assessment helped with planning the therapy for the day. Therapy lasted no more than five hours per day, and breaks were taken for Jason’s sake and to give the author and her colleague time to discuss their observations and how best to proceed.

Marks (2011) conducted a total of ten sessions with the child and his mother. She reported that she adhered to the structural model of dissociation (van der Hart et al., 2006). She constructed physical metaphors using toys, play dough, or drawings to move through the phases of stabilization and symptom reduction, processing trauma, and integration throughout the sessions.

Marks (2011) also explained important aspects of dissociation, attachment, and neurobiology as she described her sessions with Jason. Issues pertaining to dissociation

included direct questioning about dissociation; addressing shame, anger, and other emotions; identifying the dissociative parts and their functions; acceptance of all dissociative parts; obtaining the cooperation of dissociative parts; layering (Van der Hart et al., 2006); and integration of parts. Attachment issues for abused, neglected and adopted children included instilling a sense of safety, attunement and affect regulation, receiving the nurturing they missed out on, and building trust. Neurobiological concepts such as left brain and right brain functioning and the concept of freeze discharge (e.g., the need to release “the fight and flight responses that are held (frozen) in their bodies and minds due to their helplessness or developmental inabilities at the time of the trauma”; Marks, 2011, p. 114) were also addressed. Freeze discharge appears to be synonymous with abreaction.

Waters (2011). Waters (2011) described the two year treatment of an 8-year-old boy, Ryan. She initially saw Ryan when he was three years old. Ryan’s older brother, Victor, had been sexually abused by a babysitter, and he, in turn, had sexually abused Ryan. Ryan presented at that time with encopresis and appeared to be “reenacting his own sexual abuse on himself” (p. 142). He was afraid to sleep by himself, was having nightmares, and would slip into his parents’ or his brothers’ beds.

The author reported working with Ryan to increase stabilization and safety and to process traumatic memories (Waters, 2011). She reported using dolls and clay at this time; in one session she reported Ryan made a clay figure that represented his brother, and then he released his anger at his brother by pounding it. The parents ended Ryan’s treatment when Victor completed his therapy. Five years later they requested that Waters see him again.

Ryan now presented with several symptoms indicative of dissociation according to Waters (2011). He had continued to have problems with encopresis over the years. He had extreme mood swings from happy to aggressive and angry, inconsistent school performance (he had to repeat first grade), nightmares, and trance-like staring. He also had somatic symptoms that usually occurred between 2 to 5 a.m. that included nausea, diarrhea, chills, severe headache, staring, stomachache, and throwing up; Ryan did not remember these occurrences the next day. Ryan's mother reported he was inserting toys anally again. She also reported that he experienced dramatic changes in his voice and mannerism a few times a year.

Ryan had contracted several medical problems. He had been diagnosed with allergies and chronic and severe sinus infections. He had sinus surgery at age 8 and was hospitalized for a week. He was hospitalized again a month later for meningitis. He began to have chronic infections, illnesses, and was low in height and weight. He was being treated by a neurologist who suspected a seizure disorder; however his electroencephalogram was normal.

Waters (2011) noted that Victor had displayed symptoms of a dissociated state during his treatment; this state was integrated as part of his healing process. She expressed regret that she did not consider assessing Ryan for dissociative symptoms previously as the literature suggests dissociation can be a familial trait (Mann & Sanders, 1994; Yeager & Lewis, 1996). Waters remarked it is possible that Ryan was dissociating when he got into bed with his brother who had molested him as this is contradictory behavior, and that Ryan's encopresis may denote a detachment from his bodily functions, or depersonalization. Further assessment proved this to be the case as Ryan was unaware

of contractions before a bowel movement and had no kinesthetic or olfactory sense of having had a movement afterwards.

Waters (2011) applied her own Quadri-Therapeutic Model for Treatment of Dissociative Children (Waters, 1996) in her interventions with Ryan. It integrates Dissociation Theory, Attachment Theory, Developmental Theory, and Family Systems Theory. This theoretical perspective places an emphasis on also including supportive parents in sessions. Waters met with the parents before each session. She provided psychoeducation to them regarding trauma and its effects, the mechanics and symptoms of dissociation, and ways to support Ryan at home and school. She included Ryan's mother and father, when his schedule permitted, in sessions with Ryan's permission. This helped the parents to recognize dissociative states; it helped fill in lapses in Ryan's memory; and it helped with the attachment between the dissociative states and Ryan's mother.

Waters (2011) began working with Ryan by helping him to gain awareness of his bodily sensations. She used drawings and visualization to help Ryan reconnect his brain to his bodily sensations.

Waters (2011) then confirmed the existence of parts, noting the importance of assessing for internal auditory and visual hallucinations. She worked with Ryan to determine their origin and function. She gave attention to accepting all parts, thanking them, and gaining their cooperation. Waters recommended primarily speaking to the dissociative parts through the presenting child. However, if another state presented in the session, she acknowledged the importance of treating this state with respect and speaking to it. She discussed working with parts on age progression or regression. She put

emphasis on developing coconsciousness, increasing communication and internal cooperation among the parts, and gaining control over switching. As parts were integrated, they were given a new name and a new function.

Like Marks (2011), Waters (2011) also addressed working through feelings of shame and anger, attachment issues, and safety issues. She addressed issues that had not occurred in the other cases including switching without a trauma trigger and having an anniversary reaction. She reemphasized the importance of collaboration with teachers and parents. Waters noted that working on symptoms without addressing the cause will not help in the long term trauma processing.

Waters (2011) worked with Ryan and his family for 52 sessions over a two-year period. Drawing was a primary mode of treatment as Ryan liked to draw. However, she also incorporated the use of metaphors and clay.

Synthesis and analysis. The greatest obstacle to treatment in these cases appears to remain the difficulty in diagnosing dissociative disorders in children. Earlier cases did not yet have access to some of the research regarding assessments and knowledge of a familial factor. Albini and Pease (1989) and Snow et al. (1995) both noted dissociation in another family member further emphasizing the need to consider the familial component. However, for more recent cases, Marks (2011) is the only author who described her assessment process and indicated the use of the Child Dissociative Checklist. Waters (2011) admittedly overlooked the possibility of dissociation even though she had observed dissociation in the child's brother previously. Only one case noted the diagnosis occurred during the assessment (Fagan & McMahon, 1984). The other cases demonstrate the importance of on-going assessment to reach the proper diagnosis.

These cases ranged from two months to five years before the correct diagnosis was made. Treatment lengths ranged from three sessions to three years after correct diagnosis. This appears to add support to the research that treatment in children takes less time (Fagan & McMahon, 1984; Kluft, 1984a, 1985b, 1985d).

Models and Theories of Dissociation

Different theories have been suggested to explain the development of dissociation in adults. Three theories of dissociation may help to explain the development of dissociation in children and help to guide diagnosis and treatment: The Discrete Behavioral States Model (DBS; Putnam, 1997); the Disorganized Attachment Model (DA; Liotti, 1992, 1999, 2009); and the Theory of Structural Dissociation (Steele, Van der Hart, & Nijenhuis, 2005; Van der Hart, Nijenhuis, & Steele, 2006).

Discrete behavioral states model.

The development of discrete behavioral states. Putnam (1997) refers to a discrete behavioral state “as a specific and unique configuration of a set of psychological, physiological, and behavioral variables” (p. 153). He based the DBS model primarily on the work of Wolff (1987) who studied the development of behavioral states in infants. Wolff used combinations of continuous and dichotomous variables (e.g., respiratory rate, eye movement patterns, activity level, and facial expression) to classify infant behaviors into distinct states. For example, when the infant displays low motor tone, low motor activity, relaxed face, closed eyes, and regular, rhythmic breathing, the infant is said to be in State I, non-rapid-eye-movement (non-REM) sleep. However, when the infant shows increased motor tone, regular movements of the trunk and limbs, alternations in facial expressions (e.g., relaxed, smiling, frowning, grimacing, precrying), horizontal and

vertical movements visible through closed eyes, and increased respiratory rate, the infant is in State II, irregular or REM sleep.

Responses to a stimulus are state-dependent, i.e., different responses are produced depending on what state the infant is in (Wolff, 1987). Infants in State I can be picked up and dressed without being awakened, whereas, infants in State II are easily awakened by such movements.

Newborn infants are born with five behavioral states (Wolff, 1987). These different behavioral states operate within a larger framework called a behavioral state space. The infant's behavior transitions among these states in an orderly cycle. However, rather than being smooth and linear, these transitions are discontinuous and jumpy. Putnam refers to the transitions as "switches" (Putnam, 1988). Figure 2 helps to explain this conceptualization.

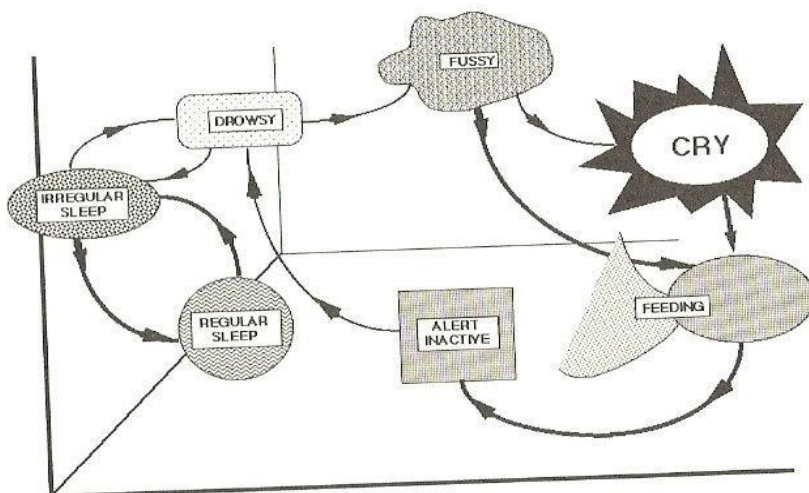


Figure 2. Infant DBS at one month. From *Dissociation in Children and Adolescents: A Developmental Perspective*, Putnam, 1997, p.156. Copyright Guilford Press. Reprinted with permission of The Guilford Press.

As the infant grows, new states and pathways continue to develop based on interactions with caregivers, and the behavioral architecture becomes more complex. Branching of pathways between states leads to new behavioral sequences and the ability to by-pass states as shown in Figure 3 on the next page. These processes continue throughout life.

The experience of continued transitions among states leads to the creation of stable neuronal pathways. The pathways form a behavioral architecture that describes an individual's personality. Discrete states are self-stabilizing and self-organizing over time (Wolff, 1987). Although individuals can travel multiple pathways, they tend to travel in predictable patterns.

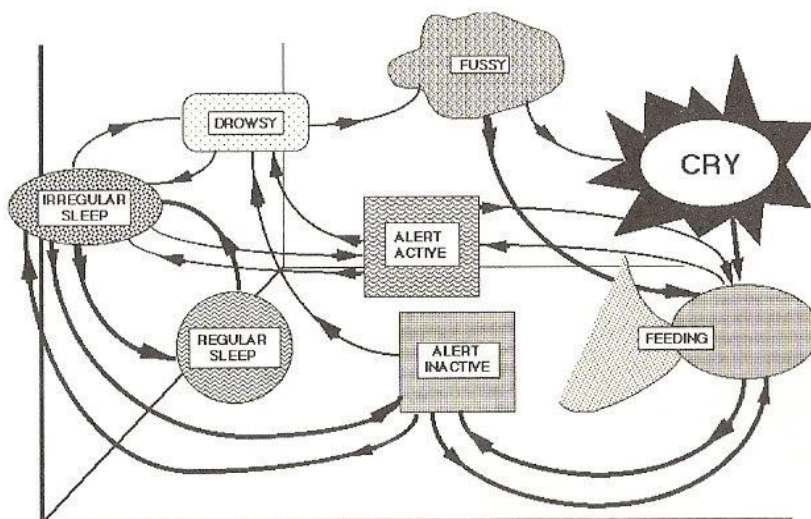


Figure 3. Infant DBS at 3 months. From *Dissociation in Children and Adolescents: A Developmental Perspective*, Putnam, 1997, p.156. Copyright Guilford Press. Reprinted with permission of The Guilford Press.

The regulation of behavioral states. As the infant develops and more states are created, the child must learn to regulate them. According to Putnam (1997), this is another “type of strand in the developmental web” (p. 160). The regulation of behavioral states requires three abilities. The first is the ability to maintain a desired state in spite of distractions or other upsetting stimuli. The second ability enables the infant to recover from an interruption and regain the desired state. Lastly, the infant must be able to enact a behavioral state that matches the situation.

Initially, the child tries to gain control over its behavioral states through self-soothing and self-stimulating behaviors (e.g., sucking its thumb). The parent, or caregiver, also modulates the infant’s states by intervening to meet its needs. There is reciprocity between the infant and parent, a mirroring and sharing of states, that leads to attachment between the parent and child. Putnam (1997) noted work by Field (1985) that demonstrated the positive impact on physiological processes between the mother and child when their behavioral states were synchronized and the strong negative effects when they were not attuned to each other.

The development of metacognition and integration. Putnam (1997) asserts that the child develops behavioral-state-integrative metacognitive processes as a toddler and in early childhood, i.e., the ability to “integrate information and behavior across different states” (p. 162). Young children demonstrate a dependency on state and context in their ability to remember information. They need help in learning to generalize information to other states and contexts. Parents and caregivers are essential to this process.

Studies indicate that children’s sense of self is also state and context dependent (Wolf, 1990). As they mature, children develop an authorial self and are able to integrate

the state and context dependent senses of self. This enables the child to choose various aspects of self to emphasize in different situations. This metacognitive integration is demonstrated in the child's ability to engage in fantasy play (Putnam, 1997).

The impact of trauma on behavioral states. Discrete behavioral states are continually developing and are impacted by interactions with others and other stimuli (Putnam, 1997). Exposure to trauma can interrupt existing behavioral state loops and create new pathways. Continued exposure to trauma can impact the child's ability to regulate behavioral states, i.e., maintain his behavioral state during the trauma, recover from the trauma and regain his behavioral state, and react with a behavioral state that matches the situation. Putnam observes how this can be explained by the neurobiological model of Perry, Pollard, Blakely, Baker, and Vigilante (1995). The model explains how the repeated activation of neural networks leads to use-dependent neural responses and sensitization. When the neural response pattern to trauma becomes sensitized, the response can be triggered by a less intense stressor.

Putnam (1997) focuses primarily on maltreatment as the cause of trauma and appears to presume it is inflicted by the parent. The assumption is that the maltreated child has a disorganized attachment with the parent. Abusive parenting interferes with the child's metacognitive abilities to integrate knowledge and his sense of self.

The DBS model and dissociation. The DBS model explains pathological dissociation "as a category of trauma-induced discrete behavioral states that are widely separated in multidimensional state space from normal states of consciousness" (Putnam, 1997, p. 173). The amount of separation between normal and dissociative states is hypothesized to be influenced by four factors:

1. The distance between the state-defining variables in state space (e.g., heart rate, level of arousal, affect, etc.) may be very different in a dissociative state than in a normal state.
2. The state dependency of information encoded in a normal or dissociative state impacts the degree of separation. Information encoded in one state may not be accessible in another state, especially one that is very different.
3. The structure of the pathways linking the states can impact the amount of separation in various ways. A direct connection between states is assumed to be closer than pathways that must go through other states. States that share multiple interconnecting pathways are assumed to be closer than states that only share one connecting pathway. States at the far ends that are not frequently travelled are assumed to be farther apart.
4. The metacognitive integration of knowledge and a sense of self is hypothesized to be outside of state space. This allows an individual to observe his or her behavior in whatever state the person is in; this assumes the individual has the ability to be reflective. It is believed that this function promotes the integration and stability of identity and behavior across daily variations in behavioral state. It is hypothesized that this function is disrupted by early trauma in childhood.

Putnam (1997) uses these factors to explain dissociative phenomena. In dissociative amnesia, the DBS model hypothesizes that information that is accessible in a normal state cannot be retrieved while in a dissociative state due to the state dependency of the information. It hypothesizes that depersonalization is due to a failure of the metacognitive functions to observe and reflect on one's state.

The DBS model (Putnam, 1997) postulates that the alter states of MPD are discrete dissociative states formed as a result of early trauma that continue to develop throughout childhood and adolescence. Repeated trauma results in more frequent use of the state leading to differentiation and increased self-organizing and self-stabilizing characteristics. The model predicts that the information for traumatic experiences will be highly state-dependent for the alter state and not easily retrievable in other states.

Another factor hypothesized to contribute to the development of MPD is the failure of metacognitive functions (Putnam, 1997). The DBS model predicts that the metacognitive abilities of children are less developed, and therefore, more easily disrupted. Therefore, it predicts that earlier trauma will result in a greater degree of dissociation.

The DBS model (Putnam, 1997) proposes that pathological dissociation is different from normal dissociation. Pathological dissociation involves amnesia and changes in identity that are state dependent. Normal dissociation involves absorption and a narrowing of attentional focus. Accordingly, there is not a wide separation from normal states of consciousness.

Disorganized attachment model.

Foundation in attachment theory. Liotti's (1999, 2009) DA model of dissociation evolved from attachment theory (Bowlby, 1969/1982, 1973, 1980). Bowlby theorized that humans have an innate propensity to seek comfort and care from the parent, or attachment figure, in order to survive. The attachment system is activated when a child, or individual, experiences fear, emotional or physical pain, or loss of the attachment figure. Based on repetitive patterns of care giving interactions, the child forms

implicit memories that are gradually synthesized into memory structures that Bowlby referred to as internal working models (IWMs). The IWM guides the child's expectations about the parent and future attachment relationships. Bowlby states that this innate motivation is "from the cradle to the grave" (Bowlby, 1979, p. 129).

Ainsworth and her colleagues (1978) expounded on Bowlby's (1969/1982, 1973, 1980) work with the Strange Situation (SS). They described how attachment behaviors are shaped by the parent's interactions with the infant into the following three attachment patterns: secure, insecure-avoidant, and insecure-ambivalent. The IWMs of these attachment patterns are organized and coherent.

However, some of the infants did not fit into any of these attachment classifications. Main and Solomon (1990) studied these infants. They identified a fourth pattern in these infants as DA. Infants with DA displayed an array of unexplainable, conflicting, unusual, disorganized, and disoriented behaviors when the parent was present, e.g., looking away while approaching the parent, a dazed expression, sudden interruptions in movement. Notably, most of these infants did not also display this behavior in the presence of a second parent which indicates the behavior is not due to a neurological impairment.

Main and Hesse (1990) determined that the main difference between DA infants and the other infants was having a parent with memories of unresolved trauma connected to past abuse or the death of an attachment figure. They postulated that the parent with unresolved memories may behave in either a frightening (maltreating) or frightened (alarmed) way toward the child. The parent may hurt the child at times and offer comfort at other times. The parent may also become frightened by intrusive memories from the

unresolved trauma. When the infant experiences the parent as frightened, the infant may perceive that there is something in the environment that poses a threat to the parent, and therefore to the infant as well, or the infant may perceive that he or she is the threat, and therefore, frightening. In these situations, the child is faced with the unsolvable paradox that the parent is “the source and the solution of the infant’s alarm” (p. 163).

Disorganized attachment and dissociation.

Multiple IWMs. Based on the experiences of frightened, frightening, and comforting interactions with the parent, Liotti (1992) proposed that “the infant’s disorganized/disoriented attachment behavior ...correspond[s] to the construction of an internal working model of self and the attachment figure that is multiple and incoherent” (p. 199). Liotti (1999, 2009) used the analogy of the drama triangle (Karpman, 1968) to describe the possible multiple IWMs a child might have. Based on the child’s perceptions, the parent and/or child may be seen as persecutor, victim, or rescuer. Liotti proposed five combinations of representations of self and other:

- The parent is the cause of the fear, or persecutor, and the child is seen as helpless victim.
- The parent may simultaneously be represented as the rescuer; even though the parent is frightened due to the intrusion of unresolved memories, the parent is able to provide comfort.
- The child perceives self as evil, the persecutor responsible for the parent’s fear.
- The self and parent are both perceived as victims of an unknown threat.
- The child perceives self as the rescuer providing comfort to the parent.

Liotti (1999, 2009) noted the three IWM representations in DA are similar to the main forms of alter ego states in DID: persecutor, victim, and rescuer ego states (Ross, 1989). He hypothesized that infant DA may be an antecedent to dissociative disorders.

Pathways to dissociation. Liotti (1999, 2009) postulated that the IWM of DA is a critical factor that may lead the child to respond with dissociation to trauma. According to attachment theory, the attachment system is activated when the child experiences fear, pain, or loss. In response, the child seeks out the protective proximity of the parent. However, the IWM guides how the child approaches this search, and it may even hinder it. The IWM of DA not only inhibits the child's search for comfort, but it actually increases the experience of fear. The IWM guides the child to expect to be frightened further when approaching the parent in fear, or to be frightening to the parent. It therefore, creates a "paradoxical loop of frightening and contradictory meanings" (Liotti, 1999, p. 303-304). The child is unable to reconcile the situation and resorts to dissociation.

Stated another way, Liotti (2009) posits that dissociation is "primarily a failure in the integration, into a unitary meaning structure, of memories concerning attachment interactions with a particular caregiver" (p. 59). This failure is attributed to an inter-subjective experience that is frightening to the child. However, the frightening part of the experience is not always due to abuse or violence: it may be the result of the caregiver responding in a frightened or dissociated way to the child's need for protection. Once it is developed, the IWM of DA increases the likelihood for responding with dissociation to any future trauma because it reactivates the multiple and incoherent representations of the self and other.

Liotti (1992, 2009) hypothesized that DA increases the vulnerability to respond to future traumas with pathological dissociation along three potential developmental pathways. In the first pathway, if the caregiver is able to resolve the traumatic memories and/or no other traumas occur, the multiple IWMs will gradually integrate: A low vulnerability exists to respond with dissociation to future life stressors. A second pathway presupposes that if the child is exposed to other risk factors, it may lead to a mild dissociative disorder. If the child experiences repeated traumas, the third pathway predicts more serious forms of pathological dissociation will develop, including DID.

Theory of structural dissociation. Steele et al. (2005) state that the theory of structural dissociation they propose is founded primarily on the work of Pierre Janet (as cited in Steele et al., 2005). However, it is also an integration of other theories designed specifically to address structural dissociation caused by trauma (Van der Hart et al., 2006; Steele et al., 2005). The term, trauma, is often used to mean a traumatic event. However, Van der Hart et al. (2006) acknowledge that not everyone who experiences a traumatic event will be traumatized. Thus, they define trauma to mean an individual who has experienced a degree of structural dissociation as the result of a traumatizing event, and who has subsequently developed a trauma-related disorder (p. 24).

Structural dissociation. Janet (1907) viewed dissociation as divisions of the systems that make up the personality (p. 332). Therefore, the personality can be considered a structure composed of numerous systems. Van der Hart et al. (2006) consider the personality to be a system that is made up of psychobiological systems that function in an organized and cohesive way. When trauma occurs, this organized system divides along “evolutionary metaphorical ‘fault lines’ in the structure of the personality”

(Van der Hart et al., 2006, p. 3). They, therefore, refer to this division as structural dissociation of the personality (Nijenhuis, Van der Hart, & Steele, 2002; Steele et al., 2005).

When a structural division occurs, it takes place mainly between two primary types of psychobiological systems, referred to as action systems, because they each have their own innate action tendencies to behave in goal directed ways (Van der Hart et al., 2006). Action systems help us to differentiate between hurtful and helpful experiences and to produce the optimum adaptive response to the present situation (Steele et al., 2005; Van der Hart et al., 2006). One action system is focused on activities of daily living and continuation of the species, e.g., work, play, reproduction, attachment, sleeping, eating, care giving, sociability; the other is focused on defense, i.e., escaping and recovering from threatening situations (Steele et al., 2005, p. 17).

Fault lines develop between these action systems because it is not possible to attend to both at the same time (Steele et al., 2005; Van der Hart, 2006). When faced with persistent trauma, some individuals cope by dividing their personality into parts to carry out the contradictory goals of these action systems. Van der Hart et al. (2006) adopted the terminology ascribed to these dissociative parts by Charles Myers (1916a, 1916b, 1940): the apparently normal part of the personality (ANP) and the emotional part of the personality (EP).

The ANP is fixated on carrying out the actions of daily life, and therefore, avoids reminders of the trauma. The EP remains fixated on trauma memories, and therefore, continues the actions systems that were operating at the time of the trauma as if it is still happening; these action systems include defensive subsystems that include flight, freeze,

hypervigilance, fight, etc. (Van der Hart et al., 2006). Myers (1940) did not use the term EP to mean that only this part experienced emotion. The ANP also experiences emotion. The emotion experienced by the EP, however, is vehement emotion that is overwhelming and maladaptive (Van der Hart et al., 2006, p. 5)

Levels of structural dissociation. Van der Hart et al. (2006) have identified three levels of structural dissociation to describe the division of the ANP and EP: primary, secondary, and tertiary. Each of the levels correspond to categories of diagnoses in the DSM-IV-TR (APA, 2000), and each level has its own considerations for treatment.

Primary structural dissociation. Primary structural dissociation is the simplest division of the personality. It usually develops in response to a single trauma (Van der Hart et al., 2006). The personality splits into one ANP and one EP. The ANP is the predominant part of the personality at this level. The EP is unelaborated and very limited but may intrude on the ANP when triggered. Primary structural dissociation is characteristic of simple forms of Acute Stress Disorder (ASD), PTSD, and dissociative disorders.

Secondary structural dissociation. Secondary structural dissociation may develop when an individual experiences continued, severe trauma (Van der Hart et al., 2006). It consists of a single ANP and two or more EPs. This level of structural dissociation may occur when action systems of defense fail to integrate. The degree of complexity at this level depends on the number of EPs. If there are only two EPs, one has usually experienced the trauma and the other has observed it: The ANP still maintains the majority of the functioning. As more EPs develop, they may have different degrees of autonomy, separateness, and elaborated characteristics such as gender, age, and name.

They may hold different psychobiological configurations, including various combinations of cognitions, affects, motor actions, and perceptions. EPs formed due to child abuse or neglect may also have disorganized attachment patterns that interfere with the attachment pattern of the ANP (e.g., Liotti, 1999a, 1999b; Main & Solomon, 1990). If an individual has experienced many traumatizing events, there may be various sets of EPs for each trauma. Secondary structural dissociation may be indicative of the following diagnoses: complex PTSD, trauma-related Borderline Personality Disorder (BPD), and DDNOS.

Tertiary structural dissociation. Tertiary structural dissociation is the most complex level of dissociation of the personality (Van der Hart et al., 2006). It consists of more than one ANP and multiple EPs. New ANPs can develop in either of two circumstances: (a) when the individual encounters unavoidable events in daily life that trigger traumatic memories due to generalized learning or (b) when the ability of the ANP is too overwhelmed with functioning in normal life. Each ANP may assume control over certain action systems of daily life. Unlike EPs who are evoked by traumatic memories, ANPs are brought forth to carry out specific functions of the individual's life, e.g., work, parenting, sexual activity. In all instances of tertiary structural dissociation, more than one part may have a strong level of separation, autonomy, and elaboration. This level coincides with the DSM-IV-TR diagnosis of DID.

Development of structural dissociation. Steele et al., (2005) presume that, in the case of primary structural dissociation, the personality system was fairly integrated before experiencing trauma (see also Van der Hart et al., 2006). However, children who are traumatized have not reached this level of development. Thus, an adult, who experienced chronic traumatization as a child, is likely to develop a higher level of structural

dissociation due to the lack of a coherent and cohesive personality in the child. The degree of structural dissociation appears related to interactions among (a) the age, developmental level, and mental ability; (b) the duration and severity of the trauma; (c) the existence of peritraumatic dissociation; (d) family history of mental disorders; (e) level of social support, including quality of attachment relationships; (f) interruption of the usual integration of action systems dependent on a secure attachment bond; and (g) factors that impact resilience (Steele et al., 2005, p. 19; Van der Hart et al., 2006, p. 84).

Steele et al. (2005) also connect the development of structural dissociation to Putnam's (1997) discrete behavioral states, which they equate to action systems. As the infant's sense of self is very much state-dependent (Wolf, 1990; Wolff, 1987), the infant needs positive, secure, parent-child interaction to increase neural pathways and gain the ability to maintain, regulate, and integrate discrete behavioral states. The establishment of such a relationship and the repeated use of neural networks lead to a more integrated personality and a child who is well adjusted to life with others (Lyons-Ruth, 2003). Structural dissociation occurs when the discrete behavioral states, or action systems, fail to integrate due to both (a) undeveloped brain functions and structures and (b) poor dyadic modulation.

While recognizing the connection between DA and dissociation (Liotti, 1992, 1999, 2009), Steele et al. (2005) posit that DA is not really disorganized. "The conflict between approach and avoidance that cannot be resolved by the child promotes a structural dissociation between parts fixed in various attachment actions or in defense actions that conflict with each other (p. 20). Ergo, they believe that the defense and attachment systems are organized within parts, but are not organized across parts.

Factors impacting integration. Action systems and their accompanying action tendencies are usually thought of in terms of behavior. However, other than automatic behavior, most behavior is influenced by a myriad of mental actions, e.g., predicting, planning, feeling, wishes, or thinking. Thus, action tendencies are a combination of motor and mental actions. Action tendencies can be adaptive or maladaptive (Van der Hart, 2006).

Van der Hart et al. (2006) refer to three levels of action tendencies. Various levels of low, medium, and high order action tendencies were first described by Janet as the “hierarchy of action tendencies” (p. 8). Each level has stages of activation from latency to completion. An individual’s mental level determines his or her ability to complete behavioral and mental actions, and therefore, to adapt to the environment.

Mental level is the highest level of action tendencies an individual can reach at a given time (Van der Hart et al., 2006). It is composed of the mental energy available and mental efficiency. Mental efficiency enables an individual to focus and is related to an individual’s integrative capacity. Dissociative individuals may have (a) inadequate mental efficiency, (b) low mental energy, or (c) imbalances between the two factors that impede their ability to integrate experiences.

When an individual has a low mental level, he or she is more likely to respond to life’s challenges with maladaptive behavioral and mental actions (Van der Hart et al., 2006), known as substitute actions. Examples of behavioral substitute actions include cutting, physical agitation, and purging. Mental substitute actions may include vehement emotions; individuals may use maladaptive defense mechanisms to cope with them, i.e., denial, splitting, and projection. Although dissociation is considered to be a defense

mechanism in other theories, Steele et al. (2005) stress that it is considered a “deficit in integrative capacity” (p. 21) in the theory of structural dissociation.

According to Janet’s view (as cited in Steele et al., 2005), mental health is a function of the individual’s capacity to integrate and differentiate experiences. Integration involves several continuous mental actions. First, the individual must be able to synthesize external and internal experiences into meaningful mental structures within a given moment. Secondly, the individual must be able to synthesize experiences, functions, and knowledge across time. Synchronic synthesis occurs within a given moment; diachronic synthesis occurs across time. Synthesis involves binding and differentiating sensory perceptions, thoughts, affects, movements, and sense of self. For example, it helps an individual understand how the present situation may seem similar, but is actually different, from a past situation. The ability to synthesize experiences varies with an individual’s mental level. When synthesis does not occur, dissociative symptoms and alterations in consciousness may develop (Steele et al., 2005; Van der Hart, 2006).

Another mental action impacting integration is realization (Van der Hart et al., 2006). Realization involves two components: personification and presentification. Personification entails the individual’s awareness that the experience happened, and it happened to him or her. It constitutes ownership of the experience. Presentification is the mental action of being in the present. It means creating the present moment from the integration of personified experiences.

However, in structural dissociation, both the ANP and the EP do not have full realization of the traumatic experience. The ANP has not personified the experience. It may not be aware of the experience at all, and therefore have amnesia for the experience;

or it may be aware of the experience, but deny that it happened to “me”. On the other hand, the EP has not established presentification of the experience. The EP is not aware that the trauma has ended, and therefore, cannot act in the present (Van der Hart et al., 2006).

Maintenance of structural dissociation.

Classical and evaluative conditioning. Structural dissociation may continue even when issues impeding integration, e.g., low mental level, lack of social support, continuing trauma, etc., have been resolved (Van der Hart, 2006). Steele et al. (2005) hypothesize that structural dissociation is maintained in some individuals by various phobias that result from classical and evaluative conditioning. Classical conditioning results when the individual associates previously neutral stimuli, external or internal, with an aversive event. Evaluative conditioning refers to how an individual may be conditioned to like or dislike something: It occurs when an individual associates a previously neutral stimulus with a stimulus that the individual likes or dislikes (Van der Hart et al., 2006). Trauma survivors learn to avoid these conditioned fears. For the ANP, conditioned fears are traumatic memories of the event. Since the EP holds the traumatic memories, the ANP learns to avoid the EP. In other words, the ANP develops a phobia of the traumatic memory (Nijenhuis et al., 2010; Steele et al., 2005; Van der Hart et al., 2006).

A phobia of traumatic memories leads to a succession of other phobias (Van der Hart, 2006). The phobia of trauma-derived mental actions occurs due to the trauma survivor’s feelings of shame, fear, or disgust about mental actions associated with the traumatic memory. One of the phobias that evolves from the phobia of mental actions is

the phobia of dissociative parts of the personality: the ANP develops a phobia of the EP. EPs may also develop phobias of other EPs. Due to generalized learning, the ANP may develop a phobia of normal life as more and more stimuli become associated with the EP. Other phobias include phobias of attachment, attachment loss, change, intimacy, and healthy risk taking.

Survivors use a variety of escape and avoidance reactions in response to phobias (Nijenhuis et al., 2010; Van der Hart et al., 2006). Avoidance can be conscious or preconscious. Behavioral strategies may include avoiding sexual activity or looking at one's body. Escape strategies include self-harming, using substances, or working too much. Survivors may also escape mentally by engaging in avoidance actions that lower their level of consciousness, e.g., dizziness, confusion, depersonalization, or absent-mindedness. They may also retract their field of consciousness, i.e., narrow their focus of attention. Examples of this include focusing on simple tasks of daily life or chattering endlessly. Avoidant lowering or retracting the field of consciousness are also known as phobic alterations in consciousness (Van der Hart, 2006).

Relational factors. Social influences also impact the maintenance of structural dissociation (Nijenhuis et al., 2010). When a trauma involves the loss of a close relative or other socially recognized event, the social environment, i.e., friends and relatives, apply a benevolent pressure to integrate the experience. An environment with social support that encourages processing of the trauma can be a mediating factor against trauma. However, when significant social supports deny the trauma or preclude discussion of it, then dissociative tendencies are continued.

Summary

This chapter has established the etiology of dissociative disorders in childhood and the correlation of trauma, attachment, and family history. It has explored in depth the continuing need for diagnostic criteria specifically for children. The existing literature on diagnosing dissociative disorders in children is based largely on clinical experience. Case studies have demonstrated a lack of consideration of dissociative disorders in most initial assessments; diagnostic difficulties due to symptoms in children that are similar, but do not exactly mirror those in adults; and shorter treatment times. The three theories presented add to our understanding of the role of trauma and attachment, or social support, in the development of dissociative disorders and will be a basis for examining the cases in this study. Chapter Three will provide an explanation of the methodology and research design to be used in this study.

Chapter Three – Methodology

A qualitative collective case study design was used to explore the process involved in the diagnosis of children with dissociative symptoms or disorders. The diagnosis of dissociative disorders is often overlooked or misdiagnosed (Hornstein, 1993, 1998; Nemzer, 1998; Peterson, 1998; Zoroglu et al., 1996). Previous case studies have not provided detail as to the process of diagnosing dissociative disorders. This study analyzed cases from the beginning of treatment to discover how the diagnosis was recognized and what common themes may exist to expedite the diagnosis. This study may help counselors inexperienced in the diagnosis of dissociative disorders to make a more expedient diagnosis, and in so doing, provide the most effective treatment in order to alleviate the pain and suffering that accompanies these disorders.

Research Design

The research design for this study was a collective case study. Yin (2012) identified three reasons to use a case study design: (a) to gain an in depth understanding of a phenomenon that results in new learning; (b) when research questions ask what, how, or why; and (c) to allow the exploration of a phenomenon within its natural setting. Collective case studies are chosen to demonstrate a replication logic (Yin, 2012) where each case demonstrates similar results or contrasting results based on the conceptualization. Replication logic is not the same as the sampling logic used in quantitative studies. The purpose of a collective case study is not generalization (Miles & Huberman, 1994; Stake, 1995; Yin, 2012). It is to "maximize what we can learn" (Stake, 1995, p. 4).

A case study design is used to investigate a bounded system (Creswell, 1998). This case study was bounded by time, place, and issue (Creswell, 1998). The time of each case was from the beginning of treatment, e.g., the initial intake assessment, up to the submission of the research proposal to the IRB. The case study was bounded by place in that all data was gathered from the same counseling center. It was also bounded by the issue being studied, i.e., dissociative disorders in children.

Sample

The sample for this study was drawn from the archival records of a private practice counseling center in Florida. The counseling center sees clients with a variety of mental health issues and diagnoses as well as all ages. The sample is comprised of children who have been diagnosed with a dissociative disorder or have exhibited dissociative symptoms at any point in their treatment. For the purposes of this study, a child is identified as a person under the age of 12. The child must have been under the age of 12 at the beginning of treatment.

Sampling Scheme

Stake (1995, 2005) emphasizes the importance of choosing cases based on maximizing what can be learned from them. Therefore, cases for qualitative studies are usually chosen according to a purposeful sampling scheme (Bogdan & Biklen, 2003; Creswell, 1998). A maximum variation sampling scheme (Miles & Huberman, 1994) was used to select cases that demonstrate differences and commonalities.

Sample Size

Qualitative studies focus on small sample sizes in order to obtain thick rich data and a more in depth understanding of the issue being researched (Creswell, 1998; Miles

& Huberman, 1994). The researcher determines the sample size based on the value of the data collected. When no new data is being received, the criterion of redundancy has been met (Lincoln & Guba, 1985). I intended to use four case studies from archival data that were representative of different levels of dissociation. However, due to Institutional Review Board restrictions, I was only able to use the data from two cases.

Data Sources

Case studies are best conducted using multiple sources of information in order to reach triangulation (Creswell, 1998; Yin, 2012). Yin (2012) identifies six sources of information: archival records, interviews, documents, direct observation, participant observation, and physical artifacts. Although this study used archival information, i.e., information that has already been gathered, this archival data consisted of multiple sources of information from each of the identified categories. In addition to these, Janesick (2004) states that it is a “fact that the researcher is the research instrument” (p. 103).

Interviews. The records that were used were created by this researcher as I was also the therapist providing treatment to these children. As such, each session could be considered an interview whereby I asked questions pertaining to the treatment, e.g., symptoms, behaviors, progress, and the parent and/or the child provided detailed descriptions (Stake, 1995). I oftentimes recorded exact quotes of the symptoms, behaviors, and events that were described in my progress notes or psychotherapy notes to ensure retention of the client’s meaning in a later review of the chart.

Documents. The progress notes become part of the official chart record. The documents in the chart record are another source of information. Other standard

documents in a chart record include the initial intake information, a symptom checklist, correspondence, assessments, legal documents, school records, and medical records.

Observations. I also used participant and direct observations as sources of information. In my role as therapist, I would be considered a participant-observer. During sessions, I observed the affect and behavior of the children and caregivers. These observations are noted in my progress notes and/or psychotherapy notes. In this sense, these notes become data collection forms (Creswell, 1998). In addition, when permission was given, some of the sessions were recorded on DVD. I had hoped to be able to review them for more detailed analysis as an observer, but I was not able to use them. This will be discussed further in Chapter Four.

Physical artifacts. Physical artifacts include any physical evidence (Yin, 2009). I planned to use DVDs as one component meeting this criterion. Other items that were collected included pictures of sand trays and art work.

Researcher. I am a doctoral student at the University of South Florida. My program of study is in Counselor Education with an emphasis on counseling with children and play therapy. I have received doctoral level training in Qualitative Research Design and Data Collection. Play therapy coursework completed includes: Counseling Children, Group Theory and Practicum with Children, and Family Therapy and Techniques.

I am a Licensed Mental Health Counselor (LMHC) in the state of Florida. I have taken additional courses and obtained additional supervision to be credentialed as a Registered Play Therapist. I have worked in both a community agency and private

practice setting. I have a broad range of experience working with children, adolescents, and adults. However, my area of specialization is with children and families.

I had no previous experience with dissociation when a psychiatrist referred a child to me that he had diagnosed with a dissociative disorder. I informed him that I did not have experience in this area, but he said that no one else locally did either. He felt that my background as a Registered Play Therapist would be beneficial. I agreed to work with the child he referred on the condition that he would consult with me while I continued to learn about the disorder.

Since that time, I have done extensive reading and research on the theory, diagnosis and treatment of dissociative disorders in children. I have continued to consult with the psychiatrist as well as obtaining supervision from Sandra Wieland, PhD. Dr. Wieland is a clinical psychologist, consultant, and a certified play therapist (in Canada) with extensive experience working with children, adolescents, and adults with traumatic histories. She has also published several books and conducted workshops and courses on trauma and dissociation. I became a member of the International Society for the Study of Trauma and Dissociation (ISSTD) and attended their conferences. I have also taken an intensive on-line course, Assessment and Treatment of Traumatized Children and Adolescents with Dissociative Symptoms and Disorders, through the ISSTD.

Data Collection Procedures

All archival data was obtained from a private practice counseling center in Florida. The researcher is a partner in the practice and has access to the records of her clients. All records are kept in a secure location according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and according to the American

Counseling Association (ACA; 2005) Code of Ethics. All identifying information was removed from any records used to protect the confidentiality of the clients. Each child was given a different name for this study.

Before moving forward with the study, approval was obtained from the Institutional Review Board (IRB) at the University of South Florida. It was expected that this study would qualify for exemption according to the IRB criterion 6.4:

Category 4: Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. (Exempt Review of Human Subjects Research, HRPP Policy No. 303. Retrieved from http://www.research.usf.edu/dric/hrpp/irb_policies/revised/Policy%20303%20Exempt%20Review%20of%20Human%20Subjects%20Research.pdf)

An exemption would mean that obtaining informed consent would be waived. However, the IRB did not exempt the study. Therefore, I was required to provide parents, or caregivers, information about the study and obtain their consent to use their child's information in the study. The consent form can be found in Appendix A. As a result, only two releases were obtained. A third consent form was signed; however, the caregiver later revoked her consent.

Establishing Trustworthiness

Quantitative concepts of validity and generalizability are incongruent with the qualitative research paradigm (Lincoln & Guba, 1985). Rather qualitative research is

evaluated based on trustworthiness. Trustworthiness was established for this study by using strategies to ensure credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These concepts are the qualitative equivalents to the quantitative concepts of internal validity, external validity, reliability, and objectivity, respectively (Lincoln & Guba, 1982).

Credibility was established in this study by using strategies of prolonged engagement and persistent observation. Archival data for the first case extended over a period of 5-1/2 years, and the second case spanned one year. In addition, several sources of information were used in order to achieve triangulation (Lincoln & Guba, 1985). These included the initial intake information, a symptom checklist, progress notes, psychotherapy notes, correspondence, assessments, legal documents, school records, and medical records.

Thick, rich descriptions were used to empower the reader to determine the transferability of the information based on shared qualities (Creswell, 1998; Lincoln & Guba, 1985). Extensive details of each case were described using the words of the parent, child and others when possible. The reader can then judge whether the information can be transferred to other situations.

An external audit was performed for this study to establish dependability and confirmability (Creswell, 1998; Lincoln & Guba, 1985). The auditor is a psychiatrist with training and experience in diagnosing dissociative disorders. He was asked to review the inquiry process to confirm that it follows professional practice and, thereby, to establish dependability. A second purpose of the audit inquiry was to review the product to determine if the conclusions are substantiated from the data in order to establish

confirmability. Information about the auditor can be found in Appendix B; a letter of attestation is in Appendix C.

Creswell (1998) offers two additional strategies: a negative case analysis and clarifying researcher bias. This study did not have enough cases to attempt a negative case analysis. Researcher bias will be discussed in Chapter Four. Creswell (1998) advises researchers include a minimum of two verification procedures. This study employed six verification procedures.

Data Analysis

The collective case studies were analyzed using a within-case analysis of themes in each individual case and a cross-case analysis to describe themes common to all of the cases (Creswell, 1998). Qualitative studies can produce a vast amount of information to be analyzed (Miles & Huberman, 1994), and Creswell (1998) describes the data analysis process as a “spiral” (p. 143) to indicate the circular nature of the process. The first step in the spiral is data management. The information for each case was gathered and organized into binders to be read several times (Agar, 1980). As the material was read the first time, memos were made in the margins (Bodgan & Biklen, 2003; Creswell, 1998). Data from the progress notes and psychotherapy notes was reduced into a Treatment Summary Chart for each case. Data from the Treatment Summary Charts and other records was then analyzed and sorted into a list of preliminary codes and modified with each review (Bodgan & Biklen, 2003). The codes, or themes, from each case were interpreted to glean any lessons learned (Lincoln & Guba, 1985) as they apply to recognizing dissociative disorders in children. Then a cross-case analysis was completed to explore the themes that were common to both cases.

Summary

Chapter Three described the methodology and research design that was used in this study including the participants, sampling scheme, sampling size, instruments and data collection procedures, data analysis and verification procedures. Chapter Four will present the results of this study.

Chapter Four - Results

The first three chapters provided information about dissociative disorders and a general outline of the methodology for this collective case study. This study used archival data from several sources to explore the process involved in the diagnosis of a dissociative disorder in two children. Sources used for both case studies included the Symptoms Checklist (Appendix D), Child/Adolescent Intake (Appendix E), progress notes, psychotherapy notes, assessments, adoption studies, medical records, and school records.

Chapter Four presents the results of the study. It will begin with a description of changes that occurred early in the study as the process evolved. As the information used in this study came from chart records of my clients, a section is included to discuss researchers' use of their own cases and the strengths and weaknesses in doing that. Researcher bias and reflexivity are also discussed. The next section will provide information about the intake process and outline the format of the case presentations. The cases will be then be presented individually. Each case is analyzed using a within-case analysis to identify the themes particular to each one. A cross-case analysis will then describe themes common to both cases that may help to recognize a dissociative diagnosis earlier.

The Only Certainty is Change

Henry Wallace stated that “the only certainty in this life is change” (MacArthur, 2013). This is a truism for qualitative research. Maxwell (2009) noted that qualitative

studies may need to be modified “in response to new developments or to changes in some other aspect of the design” (p. 215). Although a proposal provides a general direction for a study, Bogdan & Biklen (2003) caution that it is not a “fixed contract” and the researcher must maintain “flexibility” as the research process evolves (p. 70). This study encountered some changes at the very beginning that were described in Chapter Three, but warrant repeating here.

The first modification occurred after submitting this study for IRB approval. As this study planned to use archival data and remove all identifying information, it was believed that it would be considered exempt according to IRB criterion 6.4 (Exempt Review of Human Subjects Research, HRPP Policy No. 303, retrieved from http://www.research.usf.edu/dric/hrpp/irb_policies/revise/Policy%20303%20Exempt%20Review%20of%20Human%20Subjects%20Research.pdf). However, the IRB determined it was not exempt, and therefore, I was required to obtain releases from the parents/caregivers in order to use a child’s information in this study.

The parent/caregiver of the child for each case was contacted via telephone. Initially three of the caregivers agreed to allow their child’s information to be used. The caregivers came to my office to sign the informed consent and release of information (Appendix A). However, one caregiver changed her mind and called to revoke the release six days later. I was unable to contact the fourth caregiver via telephone or registered mail. As a result, even though I intended to analyze four cases, I was only able to use archival data from two cases for this study.

This also resulted in a change in one of the sources of information that was expected to be used in data collection. The sessions for the child whose caregiver could

not be located had been recorded on DVD. It was hoped that reviewing these sessions could provide observations of behaviors or themes that might indicate dissociation. The data for the cases that were included in this study did not include recorded sessions.

Further consideration of the research questions and assumptions led to another change as the study progressed. The purpose of this study was to examine cases of children diagnosed with a dissociative disorder in order to answer two research questions:

1. How can dissociation be recognized earlier in children? For the purposes of this study, a child was defined as a youth under twelve years old at the beginning of treatment.
2. What common themes may help in the early diagnosis of a dissociative disorder?

In addition, this research study was guided by two assumptions. The first assumption was that there is a lack of suspicion (Kluft, 1985a) on the part of clinicians when it comes to diagnosing dissociative disorders in children that is due to a lack of training. This leads to misdiagnoses as dissociative disorders are overlooked in the differential diagnosis in favor of other more common diagnoses with similar symptoms. The second assumption was that identifying common themes in the cases presented could lead to a more expedient diagnosis of dissociative disorders in children.

Upon further consideration of the research questions and the assumptions, it became clear that the initial conceptual framework did not fully account for all of “the key factors, concepts, or variables – and the presumed relationships among them” (Miles and Huberman, 1994, p. 18). Conceptual frameworks are often reworked as understanding of an issue changes (Maxwell, 2009). Although the initial conceptual framework contributed to an understanding of how dissociation may develop, the factors

of trauma and attachment were only part of the framework for understanding how dissociation could be diagnosed earlier. The revised conceptual framework shown in Figure 4 depicts more clearly the assumptions made regarding the clinician's level of training and the recognition of common themes, or factors, leading to an earlier diagnosis of a dissociative disorder. Although trauma and attachment are important factors to consider in the development of dissociation, it is assumed that there are other factors that are important to consider in recognizing dissociative disorders in children.

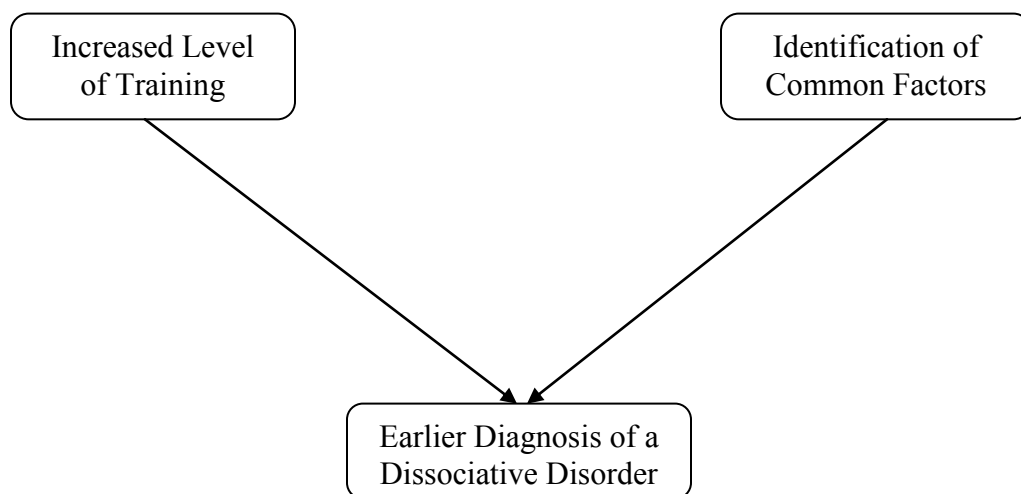


Figure 4. Relationship between Level of Training and Identification of Common Factors to the Diagnosis of a Dissociative Disorder.

Researching Your Own Cases

As in the cases reported in the literature review, I used my own cases for this study. This has its strengths and weaknesses for researchers. Advantages for doing this may include (a) ease of access, (b) time saved by decreasing the steps needed in the research process, (c) personal or professional usefulness, and (d) established rapport with

potential subjects (Glesne, 2006). Limitations may include (a) conflicts or confusion created by dual roles, (b) pressure to not upset a subject, (c) possible ethical or professional dilemmas, and (d) problems at the end of research (Creswell, 1998; Glesne, 2006).

Indeed, it was easier to gain access to my own cases, and it did save the time of locating cases to use. Furthermore, I did believe my analysis would help me to grow professionally. However, rapport was the main factor in my decision. Rapport denotes comfort in a relationship. Glesne (2006) refers to rapport as a “trust-building mechanism” (p. 110). Trust is a crucial element in qualitative research; participants are more likely to provide information when they trust the researcher (Lincoln & Guba, 1985). I had established trusting relationships with my clients. Therefore, I felt that my clients would be more comfortable allowing me to use their information than would the clients of other therapists who had no rapport with me.

The use of archival data reduced some of the possible limitations of using my own cases in this study. The data was collected while I was in the role of therapist without the thought of research, so there was no confusion about the two roles with my clients. There was also no concern that participants were withholding information or slanting it for the sake of the study, although clients are known to also do this in therapy to gain the approval of the therapist. I do think that both adoptive parents presented the family dynamics in a more positive light initially. Once trust and rapport were established, I believe they presented a truer picture of the interactions taking place.

An ethical and professional concern did arise in this study. I was still working with three of the participants when the study was initiated. Two parents gave consent to

use their child's information immediately. They were eager to share the information about their child's treatment, including what might be considered negative information about themselves and their families, for the sake of helping others in the future. However, a third caregiver was extremely labile in her moods and highly unpredictable: She had already arrived to a counseling session twice in the last year announcing that this was the last session, only to change her mind. Of course, participation in the study was voluntary and permission could be revoked at any time. When she did give her consent, I was anxious that she would change her mind if I upset her. This had the potential to impact the treatment and could have posed an ethical dilemma. This caregiver did revoke her permission, but it was not because she got upset with me. She stated that the reason she did not want the child's information included was because it was focusing too much on the problem and showed a lack of faith in God.

Researcher Bias and Reflexivity

Qualitative researchers must be aware of their own biases in collecting and interpreting data (Lincoln & Guba, 1985; Glesne, 2006). Researcher bias can exist in any study, but I think it may be a greater concern when using your own cases. It may be more difficult to maintain objectivity as a participant-observer; there is a proclivity to go native (Angrosino, 2005). Confirmation bias refers to "the seeking or interpreting of evidence in ways that are partial to existing beliefs, expectations, or a hypothesis in hand" (Nickerson, 1998, p. 175). I have tried to be cognizant of my biases throughout the study. As the therapist providing treatment to these children when the diagnosis was made, my experience is also an integral part of this study, and the diagnostic process is tracked with

a concurrent focus on the training and development of the therapist/researcher. I will use reflexivity to share my perspectives and experiences in the process (Stake, 1995).

I also used an auditor in this study to prevent researcher bias and establish dependability and confirmability. The auditor's role is to confirm that the study followed a logical process in considering all relevant data and that the findings are substantiated by the data. Information about the auditor and a letter of attestation can be found in Appendices B and C.

Initial Intake

The diagnostic process begins with the initial intake. It is the same for all children in the age group identified for this study. When a parent contacts me to receive counseling for a child, I first ask the parent for a general description of the issue they would like help with to determine whether it is within the scope of my competency. After agreeing upon a day and time, I ask the parent to complete an Intake packet prior to our first appointment. It includes the Symptoms Checklist and Child/Adolescent Intake form as well as other administrative information. The Symptoms Checklist includes 90 symptoms that are arranged in categorical clusters to help assess attention/impulsivity, oppositional/conduct disordered behaviors, anger/aggression, depression, anxiety, abuse, somatic symptoms, and psychosis; the parent checks those symptoms that are a problem now and underlines those that have been a problem in the past. The Child/Adolescent Intake includes information about the presenting problem; Social History; Developmental and Prenatal/Postnatal History; Family History of alcohol/substance abuse, legal involvement, suicidal behavior, mental health diagnoses, physical/sexual abuse or domestic violence, and other pertinent history; Health and Medical History; exposure to

Violence and Trauma; Discipline; School History; Activities and Interests; Spiritual Background; and Support System. I use this information as a guide in conducting the initial assessment interview with the parent.

When working with young children, I meet with the parent alone at the first session. This seems to be beneficial for several reasons. For the parent it helps to build rapport by empathizing with them and providing unconditional positive regard for them. It allows parents to speak freely about their child's behaviors without monitoring the words they use. This provides a more accurate picture as they also reveal their emotional response to their child's behaviors, and it gives me a preliminary understanding of the parent's level of attunement and attachment to the child. Finally, sometimes parents may reveal things during this meeting that the child does not know about, and if he was present, the parent may not disclose the information.

I do this also for the sake of the child. Most of this session is spent talking to the parent, which I feel leaves the child feeling left out, unimportant, and as if he is the problem. This goes against my training in Child Centered Play Therapy in that I am trying to convey to the child that I am paying attention to him, I care about him, and I am trying to understand what he is experiencing (Landreth, 2002). Oftentimes parents need to "vent", and they may say things not knowing the impact it will have on their child if said in front of him. Meeting with the parent alone minimizes any shame or embarrassment the child may feel, as well as concerns the child may have that I might think they are "bad".

This intake process was followed for the following two cases. Each case begins by providing the background information obtained at the initial interview with the parent.

The cases are then unfolded using information from the available records and therapy sessions up to the point of a “conclusive diagnosis”, that is, the point at which I received corroboration of the diagnosis from other professionals. I have used the words of the parents, the children, and others when possible in order to provide thick, rich description so that the reader will be able to determine the transferability of the information (Lincoln & Guba, 1985) and gain a sense of “being there” (Yin, 2011, p. 263). As my progress notes refer to the child as “the client”, and the IRB required removal of identifying information, I have replaced this term with a pseudonym for each child to enhance the narrative.

A Treatment Summary with more details from the progress notes and psychotherapy notes for each case can be found in Appendices F and G. Specific dates could not be used due to IRB restrictions. Therefore, the Treatment Summary notes the session number and time in between sessions to provide a way for the reader to track the progression of treatment and the evolution of the diagnosis.

An Assessment Chart for each case was also created as a by-product of my analysis (Appendices H and I). The Assessment Chart is based on the ISSD (2004) *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents* in conjunction with information from other sources as discussed in the literature review in Chapter Two. Pertinent information from all sources was categorized according to the various assessments recommended including: trauma, screening instruments, symptoms, family, school, and medical history.

Case Studies

This section presents the case study for each child. Archival data was analyzed to explore the process involved in the diagnosis of a dissociative disorder in two children. It came from multiple sources including the Symptoms Checklist (Appendix D), Child/Adolescent Intake (Appendix E), progress notes, psychotherapy notes, assessments, adoption studies, medical records, and school records. Each case is followed by a within-case analysis to identify themes pertaining to the diagnostic process for each one. The chapter will close with a comparative cross-case analysis of themes common to both cases.

Emily

Emily is a 10 year-old Caucasian female of slim build with dark blond curls and bright blue eyes. Emily has a diagnosis of DDNOS. It took 5 years from the time of her first counseling session to make this diagnosis.

In the beginning. Emily's foster mother (FM) first contacted me one month before Emily's fourth birthday. She called me because I had worked approximately one year earlier with Emily's biological brother (BB) who was having behavioral outbursts after visits with his biological parents (BP); these issues were resolved using Child Centered Play Therapy. The FM reported that the BP's rights had been terminated since I last saw her, and they were in the process of adopting Emily and her brother. I had been a LMHC and a Registered Play Therapist for almost two years when she initiated counseling.

At the first session, Emily's FM checked the following symptoms on the Symptoms Checklist: careless, doesn't listen, easily distracted, restless, fidgety, can't stay

in seat, doesn't wait turn in conversation or games, tantrums, change in appetite, unable to sleep well, blames others for own faults/wrong-doing, has stolen on the sly, upset by frequent changes, and mood swings. She expressed concern that:

Emily continually puts objects and her fingers in her mouth. She is strong-willed and indifferent to any methods of discipline we've tried, i.e., behavior charts, catch her being good, time out, "throw toys away" if not picked up. We had to switch the lock to the outside of the bedroom door because Emily wanders at night. She has eaten a whole bowl of candy, colored on walls with markers, and gotten into glue and creams.

The Child/Adolescent Intake revealed that Emily lived with her FM and foster father (FF); her BB, age 5; a foster brother, age 3, who was adopted at birth; and a foster sister, the biological daughter of the foster parents, age 8 weeks. Her foster parents had been married for 8 years.

Emily's FM reported she had been removed from her BP at 9 months of age due to neglect, and had been in foster care until she came to live with them at age 2. Emily's FM stated that birth and health history records were not available in the county of her birth. It was not known whether her biological mother (BM) received prenatal care, but the FM reported that the BM used alcohol and drugs during her pregnancy and the biological father (BF) used them before conception. Emily's FM reported no surgeries, hospitalizations or major illnesses. She stated that Emily was not currently on any medication.

In addition to a history of alcohol and substance use, the FM reported the BP had a history of legal involvement, but she did not expound on it. She did not know any information pertaining to their mental health history.

Emily was enrolled in a 3-year old preschool class at a private school. Her FM reported that she will repeat this level next year. She reported that Emily got along well with others. She indicated that Emily was receiving speech therapy once per week.

Emily's FM reported that she and the FF were both involved in discipline. She stated discipline is usually "time out and remove from situation". On the Child/Adolescent Intake, she expressed that both parents agreed on discipline, and it was effective "sometimes".

Emily's FM noted that she likes to "play babies" and that her strengths are her "memory" and "organization". She stated that she usually watches 30 minutes of television per day.

The Child/Adolescent Intake asks parents to describe their child's religious involvement, if any, and whether there are any special religious, cultural, or ethnic considerations that I should be aware of. This information may explain some behaviors that I may observe and also provides the opportunity to inform the parent that it is my desire to respect their values and not impose my own on them. Emily's FM reported that she attended Sunday school and noted they were Roman Catholic.

After gathering the background history, I recommended that we initiate Child Centered Play Therapy (CCPT) with Emily as well as meeting with the FM for individual sessions to provide behavioral strategies. CCPT has been used with various age groups including adolescents and adults, but it is especially applicable to children ages 3 to 12 as

it does not rely on verbal ability; the toys become the words (Landreth, 2002). Due to Emily's age and speech delays, this seemed to be the best approach to use with her. Although several of her symptoms were indicative of ADHD, I had not met with her yet, and according to CCPT, the focus is on the child and not the problem. Therefore, diagnosis is not needed (Landreth), and one was not given.

Bizarre behaviors. Eleven weeks later, after six play therapy sessions, I met with Emily's FM. Throughout this time, she had described various behaviors, some of which were somewhat bizarre and alarming to me. At the second session, the FM had reported that Emily was terrified of various sounds including the toilet flushing, the shower, the garbage truck, and the fire alarm at school. Later she reported that Emily did not stay in her bed at night, but slept on the floor by the door. At the seventh session, the FM reported time outs were not working, and they had increased in length to gain compliance. She expressed a belief that Emily "doesn't care when we discipline her." The FM stated, "When I send her to her room, she defecates, urinates, and tears the sheets off the bed." At this session, she reported that although the number of tantrums per week was decreasing, the duration was 45 minutes to one hour. She stated, "We have to hold her. She bites, slaps, spits, and wipes her nose on our arms." The FM also described various destructive behaviors:

Emily destroyed her toddler bed. She slept on a sleeping bag for 3 months. We bought her a double bed for her birthday. One morning she climbed between the box spring and mattress and bit out the lining. She chews her clothing and her toys.

Emily's FM expressed concern that Emily could only sit for 5 minutes of play. She stated she will play with "30 – 50 things" in a 20 minute span of time. She also reported that Emily would stay at the same preschool level due to her inability to sit still.

Emily's FM also presented additional information about her early history at this session. She reported that Emily had cocaine in her system at birth. She stated that Emily and her brother were repeatedly found outside their apartment complex by a neighbor who would take them back to their apartment. One day no one answered. The neighbor took them to her apartment and called the police. The police broke in and found Emily's birth parents "passed out with lines of coke on the table." She added that Emily was hospitalized for two weeks when they first got her due to malnutrition; she weighed 18 pounds.

If you hear hoof beats. My notes over this time period revealed my concern that Emily's behaviors were due to her history of neglect and possible abuse. I remarked that three of the play sessions had themes of protection and safety. It appeared that she had developmental delays, especially emotionally, and displayed regressive behaviors. I noted that her moods at times appeared uncontrollable and non-regulated. Although Emily's AM appeared to have "above average parenting ability and ability to cope with Emily's behaviors", these behaviors were "interfering greatly with her home and school environments."

Therefore, I referred her for a psychiatric evaluation. I do not like to label children with a diagnosis. I diagnose on the side of caution, and try to give a lesser diagnosis. I sent the psychiatrist a report with a diagnosis of Adjustment Disorder with Mixed

Disturbance of Emotions and Conduct and recommended continued assessment to rule out what appeared to be ADHD symptoms and possibly Bipolar Disorder.

In the month before Emily's appointment with the psychiatrist, her FM reported more destructive behavior at home and school. I provided education to her about ADHD and behavioral strategies to use. I also recommended filial training for the FM to help build the attachment relationship with Emily.

The psychiatrist diagnosed Emily with Reactive Attachment Disorder (RAD). She referred the FM to another therapist who she knew had experience working with this diagnosis. I agreed with this referral as I had minimal experience with RAD. The FM contacted me a week later and stated she was hesitant to start over with another therapist. She stated she wanted to try the Filial Therapy. I agreed to start with this while at the same time learning more about treating RAD and consulting with other professionals.

Filial therapy. Filial Therapy was first developed by Bernard and Louise Guerney (1964) and modified by Landreth (2002) to a 10-session model. Both have been researched extensively (Baggerly, Ray, & Bratton, 2010) and found to be effective. It uses parents as therapeutic change agents by teaching them the principles and skills of Child Centered Play Therapy in a group format. Parents practice the skills learned in a thirty-minute weekly play session with their child. The parent's empathy and acceptance of their child in these sessions leads to the creation of positive new perceptions of the relationship for both parent and child.

It took approximately one month from the tenth session to recruit parents for the group. Emily's FM participated well in the Filial Therapy sessions and appeared to demonstrate understanding and increased use of the skills. She continued to report

disturbing behaviors involving destruction of bedding, urination, bedwetting, tantrums, and swiping things. At the fifth filial session, Emily's AM reported feeling "so frustrated." However, at the ninth session, she reported "since the Filial Training began, I feel more relaxed, more understanding of her. Even at home, it's different. We've really bonded. We haven't had the horrible tantrums we had in the past." At this session she announced that the adoption was finalized.

During the filial training, I attempted to consult with a psychologist regarding Emily continually putting things in her mouth. I did not receive a call back. I also contacted the therapist recommended by the psychiatrist. She stated that my treatment was "on track."

Mad at mommy. At the end of the Filial Therapy, Emily and her AM appeared to have a closer bond. However, in the ten weeks that followed, she continued to have unpredictable and changing behaviors at home including reports of: increased bedwetting, decreased appetite followed by increased appetite three weeks later, chewing the inside of her mouth until it bleeds, chewing the fingers and toes off her dolls, urination, destroying things, and "swiping things." I consulted with the therapist the psychiatrist had recommended once again as the behaviors continued. She returned the call the next day and provided suggestions. I discussed her recommendations with Emily's AM and also discussed referring her to another therapist. Emily's AM did not want to do this.

I emailed the same therapist later the same day to inquire whether it would help the attachment relationship if Emily did not attend preschool. Eight days later I followed

up with a phone call, and was able to get confirmation that this may be helpful. Emily's AM chose not to do this.

A couple weeks later, the AM reported that Emily was showing more empathy. Three weeks after that, she called to say the behavioral problems were increasing. In a session with the AM the following week, she reported they may have had a "breakthrough". She states that her husband asked Emily why she was doing these things, and Emily replied, "I'm mad at mommy." I hypothesized that Emily may be acting out anger at her BM with her AM. In a session with her adoptive brother and sister present, the AM told Emily an age-appropriate story about her birth parents and her adoption. Emily showed no recollection when showed the picture of her birth parents. She appeared distracted and had to be redirected. Afterward, she showed extended interest in playing with the people figures.

Emily's behaviors continued. A week later, her AM reported via telephone that Emily was displaying increasing aggressiveness toward her. Two weeks later, I consulted with another therapist who was experienced with RAD. A week later, the AM reported they went to Disney World for the weekend, and "she was absolutely wonderful... little things here and there, but no meltdowns or angry words. There was a notable change in her face when it was time to go home. Maybe we should loosen up at home."

The following week, I attempted to contact the therapist recommended by the psychiatrist again. I had been offered a new job, and I wanted to see if she had an opening for Emily. I attempted to call Emily's AM as well. When the AM returned my call, she reported Emily's behavior was "horrible with aggressiveness aimed" at her, including throwing her glass of water at her. The AM agreed to arrange a babysitter and call to

schedule an appointment. I did not hear from her before beginning my new job a month later, and I did not hear back from the other therapist. When Emily's AM did call, I provided the names of three therapists for her to contact. I had seen Emily and/or her AM for 35 sessions over approximately 12 months.

Starting over. Three years and one month had passed by since I had last seen Emily. I had just returned to private practice, and my first phone call was from Emily's AM. She reported that she had tried taking Emily to one of the therapists I had referred her to, but it was not a good experience. She reported that the counselor recommended she place Emily in a residential facility and go to visit her on the weekends. She reported after that, she didn't want to try again.

I was surprised that Emily's AM now reported several more symptoms in addition to those on the original Symptoms Checklist. Table 1 on the next page shows a comparison of the symptoms reported at the first and second intake sessions. Only three of the symptoms reported at the first intake were not reported on the second intake: change in appetite, unable to sleep well, and mood swings.

On the Child/Adolescent Intake form, Emily's AM reported their biggest concerns were "lying, stealing, coping with change and emotions." She stated that Emily is "constantly lying." She added that Emily "steals little things from friends at school, and the teacher's desk." She stole money from her brother. Emily's AM reported that she still has tantrums and is destructive; "she throws her dresser over, kicks walls, chews on her shirt, pulls her own hair, and blames others." She reports that her tantrums do not last as long as they did. She chews the inside of her mouth until it bleeds. Her AM also reported that Emily shows no remorse or guilt, and she still hides food.

Emily's AM also stated that Emily was not careful; she was "clumsy". She said, "She doesn't look. She just goes, and anything in her way gets knocked over." When asked, she responded that Emily's eyesight is fine and she does great at gymnastics and cheerleading.

Table 1

Comparison of Symptoms Reported at First and Second Intake Sessions

Symptoms	First Intake	Second Intake
careless	X	X
can't pay attention		X
doesn't listen	X	X
doesn't finish things		X
easily distracted	X	X
restless, fidgety	X	X
can't stay in seat	X	X
acts without thinking		X
has stolen things in plain view		X
destroys property		X
"cons" others		X
has stolen on the sly	X	X
lies when caught red-handed		X
disobeys rules		X
tantrums	X	X
complains of frequent aches and pains		X
change in appetite	X	
blames others for own faults/wrongdoing	X	X
spiteful		X
unable to sleep well	X	
fearful/afraid		X
upset by frequent changes	X	X
pulls own hair	X	X
mood swings	X	

Emily's AM reported she had difficulties in her relationships with her siblings. They now had another daughter, 17 months old. She reports the two younger girls "do

well together.” She states the three girls will play together, but “usually [the middle sister] will end up crying because Emily takes something.” Her AM states her brothers don’t want to play with her because she sucks on her fingers. They complain to AM that “her fingers are wet, and it smells.”

Emily had repeated preschool and would soon be entering third grade. She still attended the same private school. Emily’s AM reported her school performance was inconsistent: “She can read and do math one day, but not the next”. Arrangements were being made to have Emily tested by the psychologist from the county school board. She reported Emily gets along well with the kids at school.

Emily’s AM reported she had been provided with several items by an Occupational Therapist to help her emotional regulation at school and home. She has a weighted vest and a special air cushion to rock on at school; she has a bite plate and arm brush that can be used at school or home; and she has a “cocoon” and weighted comforter to use at home.

When I began seeing her again, Emily had been prescribed Tenex, Risperdal, and Daytrana. She was seeing the same psychiatrist and was diagnosed with RAD and also ADHD Not Otherwise Specified (NOS).

I did what I knew. I began working with Emily using both nondirective and directive play therapy to identify and regulate her emotions. I met with her parents to try to identify triggers for her outbursts and implement new behavioral strategies. However, Emily’s AM reported continued lying behaviors, outbursts, and changing behaviors. For example, after the fourth session, I called Emily’s AM to schedule the next appointment as her adopted father (AF) had brought her to the session. Emily’s AM told me, “It has

been a struggle with her from the time she gets up.” She relayed an incident with a blue popsicle in which “she lied and would not say it was hers.” In another phone call a few days later she stated, “We never know what Emily we’re going to get. She can change in a second and it’s hard to know what triggers it.” Emily’s AM sent an email before the seventh session reporting several changes in Emily’s behavior from trying to be helpful to having tantrums:

Emily was very helpful, sometimes too helpful ([her sister] was crying she runs from the other side [of the] house to see whats wrong and then makes [her sister] a bottle of milk....[sister] is off the bottle, has been for more than a year [....] The kids ar ein [*sic*] gymnastics camp this week.. Monday, I woke her up...very nicely, tried to ease her awake, and was greeted with immediate whining. She whined and had outbursts getting dressed, then she ate breakfast fine. When it was time to go and get shoes, again the whining, turning her feet and walking on her ankles. She had a full out tantrum in her room before going to the car. No problems at gymnastics....when she got home she ate lunch, and went swimming. She stayed in the pool foronly [*sic*] 2-3 minutes and wante dto [*sic*] change...I told her no to stay outside, we weren’t going in yet....she collapsed on the ground, put a towel over her head. She whined and grunted. She finished her fit, I had her sit quietly in a chair for a few minutes, she swam again, but not for very long. We all went in, she had speech therapy (no problems), and then something triggered a major whining and crying fit [.] I sent her to her room, and she screamed “Everyone thinks I am ugly” When she calmed down I tried to talk to her about it, but I really got no where[.] Today and tonight, everytime we ask her

to do anything from put her laundry away, turn off a light, clean a mess....we [were] met with huge whining and grunting and then usually the requested job is NEVER fully completed...laundry is thrown in [the] hallway out side [the] laundry room,,, even when I am specific about saying put it in the green basket...of course we call her back to redo the task and we [are] met with a huge fit[.]

Today in gymnastics she heard [name], my nephew, crying at gymnastics. He is five and in a different group, and area from emily. But she knew immediately that was his cry. Left her group [and] went to him (he had foam in his eye). She call me from the gym office phone t [sic] tell me he's hurt. I tell her to get his teacher, and she said he is already with her. She explained what was wrong. I assured her he was fine that his teacher would call if its serious and for her to go back to class....(they didn't know she had called me) She is doing that a lot this week with my sister being here...basically wanting to be in everyone's business..even the crying babies, and then she tells my sister (well, really yells for [her] when her kids do even the simplest things...and even if it is being handled.

After the 11th session, Emily's AM sent an email describing her frustration with not knowing how to manage Emily's outbursts:

She does not respond well at all to being called into her room to clean up, or told to pick up a mess in the playroom...what I mean is she reacts very defensive when being told authoritatively what to do...I have to figure out how to come across differently to her... she immediately gets confrontational and defensive in her reactions with everything that is not in her favor or not in her control [...]

many times I need to leave the room during a fit for my own sanity, and she will purposefully do things to try to get me to come back...kick her closet door (which usually then falls to floor), slam the window blinds until they fall...now, I hear the sound of her doing these things, I know what she is doing, and I know what will happen if I don't go back in...the closet will be on the floor, there will be a hole in the wall, the dresser will be flipped (whatever she is kicking she will continue until it is broken, flipped, or whatever) So, I struggle with should I go back in immediately when I hear those sounds, but then I feel she is in control then, and has gotten me back in there on her terms...if I don't go in..if I wait until she is calm, which is usually after the destruction..then we have more mess to clean and she has still won...but then, for every fit I can't hold her and calm her, and baby sit her to be sure she doesn't destroy[;] sometimes she is too out of control for my strength...we haven't been able to find the diffuse button yet

It was at this time that I received a phone call from a psychiatrist. He wanted to refer a child to me who he had diagnosed with Dissociative Disorder Not Otherwise Specified (DDNOS). I told him I did not have any specific experience in working with dissociation in children. He stated not many people did, and he didn't know of anyone else in our area to call. He felt my background in play therapy would be helpful. I agreed to begin play therapy with the child as long as he would agree to consult with me while I tried to find training and learn more about the disorder.

Rising suspicions. When the psychiatrist first referred that child, I remember thinking, "Really? How do you know? How can you tell?" I'd heard of it in adults. It was in the DSM-IV-TR, but I had never encountered it, and I just wasn't sure it was real.

I was skeptical. I began to read all I could and to look for trainings or someone experienced in treating dissociative disorders in children to consult with.

As I read various articles about treating dissociation in children and worked with the referred child, I began to wonder. I saw parallels between Emily's behaviors with those of the other child and with those described in the articles I was reading, e.g., inconsistent abilities, abrupt changes, aggression. Six weeks later, my note from session 17 indicated my first suspicion of dissociation: "Emily's behavior appears to be indicative of her trauma history. She appears to have dissociative symptoms, i.e., numbing, startle response, fears."

The turning point. Two weeks later Emily's AM reported that when she went to wake Emily up, she found she had defecated and wiped it all over her clothes and comforter. Her AM reported "she giggled about it." As her AM instructed her to help clean up, she reports Emily got more and more defiant: "She began jumping on the bed, hitting the ceiling fan." When her AM stopped that, she "began emptying her drawers, tried to knock her dresser over, yelling, 'I hate you!'" Her AM reported she spanked her; Emily looked at her and said, "You spanked me" as if wondering why. Her behavior was baffling to me. What was I missing? I began reviewing Emily's whole chart the next day. I emailed her AM to confirm information about medications and to inquire why Emily was not removed immediately if she was born with cocaine in her system. I informed her I planned to consult with the psychiatrist who had referred the other child to me. She responded that the Department of Children and Families (DCF) "reported to me that she was cocaine addicted at birth when we took custody. However, I requested her birth

records a few months ago directly from [hospital name] and there is no record of the cocaine with her.” She stated she would provide a copy of the birth records to me.

My review of her adoption records at this time indicated that Emily had been moved within the foster care system 12 times (from the age of 9 months until 2 years old) before she was placed with this family. The length of time for eight of these placements ranged from one to five days. Four placements were four months or less. The longest placement was for barely six months. I now knew that loss of primary attachment figures may be a form of trauma (James, 1994).

I was able to consult with the psychiatrist that referred the child with DDNOS twelve days later. He agreed that Emily’s behaviors may indicate a possible dissociative disorder. It was certainly regressive for an eight year old to defecate and then giggle about it. I emailed Emily’s AM and asked her to look for changes, i.e., “calm to aggressive; changes in abilities....”

The next parent session was a month later due to therapist illness, rescheduling, and the AM being ill. Emily’s AM reported that Emily had a “meltdown” at cheerleading. She stated that Emily’s coach commented to her, “That wasn’t Emily at practice today.” Her AM reported she was “not her” for two hours.

Emily’s AM also reported a telephone call she had with Emily’s teacher. She stated that Emily does her spelling with her (AM) and gets them all correct, but then gets a zero on the test. The teacher described an incident where Emily “was doing flips with three or four other girls on the playground. While the others kept running, Emily came to the teacher with ‘the biggest smile on her face’ and said ‘Nobody will play with me.’ The teacher directed her to the slide and then asked, ‘Why don’t you go play with the girls

over there?’ Emily acted like she hadn’t played with them already, and said, ‘o.k.’”

Emily’s AM states the resource teacher told her, “Emily has been different all week.” She told the AM that Emily was more easily frustrated. She said, “Emily will usually try when I put a paper in front of her, but this week she said, ‘I can’t do it. I’m not doing it.’”

At this session, the parents completed the Child Dissociative Checklist (CDC; Putnam et al., 1993). This form may be found in Appendix J. A cut off score of 12 is considered to be indicative of pathological dissociation. When I looked at the 20 items on the CDC, I expected that Emily would have some of them, but I was very surprised when her score added up to 26. Twelve of the items were marked “very true” including:

- trance-like states
- rapid changes in personality
- poor sense of time (her parents remarked “she thinks everything is today”)
- marked changes in skills, abilities, preferences
- rapid age regressions
- difficult time learning from experience/normal punishment does not work
- lies/denies misbehavior even when the evidence is obvious
- rapidly changing physical complaints
- unexplained injuries or injures self
- intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes
- frequently talk to him or herself, may use a different voice
- has two or more distinct and separate personalities that take control of behavior

I suspected that Emily had a dissociative disorder. Yet, I was still unsure, fearful of making a wrong diagnosis.

I was out of the office the next week, so I emailed Emily's psychiatrist 10 days after our last session to inform her of my suspicions, my research into dissociative disorders in children, and the results of the CDC (Putnam et al., 1993). I also noted that "her parents report they have not noticed any changes with the medication she is presently taking. We are wondering how much sleep she gets as her mother reports she 'hears everything'. She knows if [sister] is up in the night, if mom gets a drink, etc. She'll ask her in the morning, 'mommy, were you up last night?'" I also inquired whether any "modification to her medication" might help with her "destructive and unpredictable behavior." I asked the psychiatrist to contact me to discuss these concerns.

When I called Emily's AM to let her know I sent the email, she reported that Emily was still attempting to be "sneaky" and "deceitful." She reported Emily had asked for a cookie, but she took six instead of one. When she was asked about it, she denied it. When her parent persisted questioning her, she said, "O.k. fine. I did it, but it wasn't me."

Two days later, I met with Emily and her AM. Emily reported that she didn't remember her birthday last year, Christmas, or yesterday. I attempted to explain to Emily that sometimes when people get too worried or stressed, they might go to a different place in their mind and not remember things. Emily seemed unaffected by the discussion. She seemed upset at not being able to remember. She wanted to switch topics and activities. She tried to make a Santa, directing the therapist and mother to make parts of him, but she had difficulty making the pieces fit. She abruptly stated she wanted to leave. Then she stated she was hungry. Emily's AM visibly teared up during the session.

Emily's AM and I decided to wait to schedule the next appointment until after I consulted with the psychiatrist.

I made a phone call to Emily's psychiatrist's office after our appointment that day to follow up on the email. The psychiatrist's assistant left a voice message later that day; she requested Emily's AM call for an earlier appointment to adjust her medication. I did not receive a call from the psychiatrist.

The psychiatrist faxed her psychiatric note after the appointment a week later, noting a change in medication to a trial of Zyprexa, decreasing the Risperdal, continuing the Daytrana, and tapering off the Intuniv. She noted that the "patient's therapist, J. Reycraft, questions whether Emily might have Dissociative Disorder." Emily's AM called me to report the change in medications the next day. She stated that the psychiatrist "considers dissociative symptoms to be part of the RAD diagnosis."

There was a one month gap in counseling due to holidays and waiting to see what the psychiatrist would say. I believed that the psychiatrist had more experience and knowledge than I did, and I lacked confidence in myself, so I continued treating Emily according to the psychiatrist's diagnosis of RAD and ADHD NOS. I worked solely with the parents over the next two months (nine sessions) on improving their attachment to Emily using techniques proposed by Hughes (1997), Levy and Orlans (1998), and Maletz (2005).

Emily appeared to be responding to the techniques, so we scheduled the next session for her. It had been three months since I'd seen her. I wrote in my note "re-established rapport.... Emily was happy to see therapist; confused about where she had been."

When I knew better. Maya Angelou is credited with saying “I did then what I knew how to do. Now that I know better, I do better.” Throughout the last three months, I had been desperately looking for training in dissociation. I had started out reading everything I could find on treating dissociation in children due to that first referral, and I had begun working on my thesis, *Treating Dissociation in Children with Play Therapy: A Critical Review of the Literature* (Reycraft, 2011). Now I needed to know more of how to diagnose a dissociative disorder. Emily seemed to have many of the symptoms, but the research I found reported that the symptoms of dissociative disorders were similar to those of other diagnoses (Hornstein, 1993; Kluff, 1984), and some behaviors could be normative for her age (Kluff, 1984). Without experience, I did not feel confident.

The next week, I attended a two-day training titled *Attachment Difficulties, Childhood Trauma, and Reactive Attachment Disorder: Clinical Guidelines for Assessment, Diagnosis and Treatment* (Potter & Sullivan, 2011). It was eye-opening to me and everyone else in the room, when the presenters from the Center for Child and Family Health and Duke University Medical Center clarified what RAD is and what it isn't. The DSM-IV-TR (2000) provides criteria for RAD based on “markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years, as evidenced by either” (p. 130) emotionally withdrawn or inhibited behavior or indiscriminate or disinhibited behavior. This behavior is not due to developmental delays or Pervasive Developmental Disorder (PDD) and is related to a history of pathogenic care.

The DSM-IV-TR (APA, 2000) criteria did not include symptoms that were commonly purported to be part of this diagnosis, and the presenters referred to them as

invalidated extensions (Potter & Sullivan, 2011) of the diagnosis. They included: self-destructive behavior; destruction of property; sleep disturbance; abnormal eating habits; enuresis/encopresis; consistently irresponsible; inappropriately demanding/clingy; stealing; preoccupation with fire, gore and evil; deceitful; poor hygiene; persistent nonsense questions and incessant chattering; hoarding; cruelty to animals; inappropriate sexual attitudes; and frequently defies rules. They discussed these behaviors as responses to trauma.

Dissociation is also not mentioned in the DSM-IV-TR (APA, 2000) criteria for RAD. Potter and Sullivan (2011) discussed it as a reaction to reminders of trauma. After the training, I asked one of the presenters about dissociative disorders, especially DID in children. She responded, “Oh, we don’t believe in that” (personal communication, March 17, 2011). Indeed, I had read that there was controversy about this diagnosis and accusations in the literature that dissociation was iatrogenically created (Peterson, 1990, 1998; Putnam, 1997; Silberg, 1998c), but this was my first encounter with it. I continued to oscillate between wanting to believe it was real and doubting.

One month later, I found a recently published book edited by Sandra Wieland (2011) on dissociation in children and adolescents. Finally, I had a breakthrough! The cases presented in this book provided more detailed descriptions and explanations than the earlier cases. Several of them are presented in the literature review in Chapter Two. It provided brief explanations of some of the theories of dissociation applicable to children and my first introduction to the International Society for the Study of Trauma and Dissociation (ISSTD).

Wieland (2011) indicated that the ISSTD offered a course on Assessment and Treatment of Children and Adolescents with Complex Trauma/Dissociation. I googled the ISSTD. They had a schedule for the next course and a conference. Unfortunately, they were almost a year away! However, I did find the *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents* (ISSD, 2004); these guidelines were reviewed in Chapter Two as well.

As I read about the theories and the cases (Wieland, 2011) and considered the ISSD (2004) Guidelines, I became more convinced that dissociative disorders were real, and Emily was displaying symptoms of dissociation. However, the ISSD (2004) Guidelines included a caveat that they were not designed to be used for differential diagnosis. I felt I still needed more training to do this. I emailed Dr. Wieland two months after purchasing her book (Wieland, 2011) and inquired about any other trainings. She informed me they were just finishing the on-line course for dissociation in children and adolescents, but would probably do it again next year (personal communication, June 29, 2011).

I spent the next two months educating Emily's AM about dissociation and examining the behaviors reported. I gave the AM a chapter from Wieland's (2011) book about an adopted boy named Jason (Marks, 2011) that helped her to understand more about what was happening with Emily. Emily raged and had destructive behaviors like Jason in Marks (2011). She also had regressive behaviors like Jason (Marks), e.g., turning and walking on her ankles, urinating, sucking her fingers.

Emily's AM and I both observed more incidents that supported a diagnosis of DDNOS. For example, Emily's AM reported that she notices Emily acts younger

sometimes at home and school. She states she appears to act 9 or 10 when she is cheerleading, but she notices a change in her the “second she gets in the car to go home.” AM reports she becomes whiny and oppositional, i.e., to putting seat belt on, uses baby talk. Her AM reported she had started referring to herself by a different name at school this year. She remarked at one session that Emily will sometimes “look to the side as if she heard someone speak to her.”

In the playroom, several incidents occurred that supported the existence of alters, or parts. In one session, Emily enacted a game of “who’s the nice girl/who’s the mean girl”. In another session, she told of a dog named Buster who came to help another dog with the same name. She stated that “one dog knew about the other, but the other one did not know about this one.” At this session, Emily also disclosed that she had a friend, Bob, who came to help. I asked her to draw a picture of Bob. She reported that he was “bald” and “naked.” She gave various ages for Bob. She said that Bob dared her to do things. She reported he was there at night when she has trouble sleeping, but he does not help. Emily wanted to make a book about Bob. She started to write a name on the book, but then colored over it.

Eight days after this session Emily’s AM left a voice message for me. She was in crisis. When I called her back, she said, “It has been a fight with her from the moment she wakes up until we put her to bed....She is destroying everything....I don’t think I can do this anymore.” I met with her at my office 20 minutes later. She showed me a video clip of Emily’s behavior, which was clearly regressive. She was screaming “nop it!” instead of “stop it!”, banging a wicker basket on the floor and the wall, throwing clothes off her dresser, trying to pull the curtain from the window, jumping in and out of her bed.

This behavior went on for approximately 7-1/2 minutes while her AM tried to calm her down. Her AM asked her if she wanted a bath, and the behavior stopped abruptly. She very calmly then picked everything up. After her bath, she went to have dinner, and another switch took place. She was “splashing her fork” in her spaghetti. She took five bites and was finished. She is shown having another “fit”. As it continues, she says, “I’m hungry,” then “I’m tired.” Then she wants her dad to hold her. Then she says, “I want a taco.” Her AM asks her to show her the sores on her lip. She reports Emily has been biting her lip every day and making it bleed. She has two holes in her tongue. Her AM asks Emily if they hurt. She says “no”, then follows with “yes.” Her AM reported her behavior went on for four hours.

I described the switching behavior I saw in an email to her psychiatrist the next day. Peterson (1990, 1998) hypothesized that dissociative disorders in children were not diagnosed sooner because therapists were not asking the right questions. Yet, Silberg (1998) cautioned therapists not to ask suggestive questions due to the accusations of therapists creating the disorder in children. I was afraid to ask any direct questions of Emily for fear of doing this. I expressed to her psychiatrist, “I do not want to ‘make something that isn’t there’, but I still think she is dissociative.” I inquired about respite programs and whether there might be a need for hospitalization if her behaviors did not improve.

In a telephone call the same day to Emily’s psychiatrist, she agreed that “it does appear she is dissociating.” She stated she did not know of any residential facilities near us and recommended I consult with another therapist regarding programs. I left a message for the therapist, but it was never returned.

I contacted Dr. Wieland to arrange for a consultation regarding Emily's diagnosis and further treatment recommendations. Between this contact and the consultation, Emily's AM reported she was to be evaluated by the school psychologist. After several voice messages between us, I was able to provide background information and recommend that Emily be tested over at least three sessions due to the possibility of dissociative states. Even though this was done, Emily's scores were still inconsistent. Her AM reported the psychologist plans to do the evaluation again. Two months later, Dr. Wieland confirmed a diagnosis of DDNOS.

Within-Case Analysis

As I examined the diagnostic process in this case, I discovered several themes that may be categorized according to factors that impeded the recognition of dissociation and factors that advanced the recognition of dissociation. The themes fall within three subcategories for factors that impede recognition: (a) therapist, (b) parent, and (c) other professionals. In addition to these three subcategories, a fourth subcategory is included for factors that advance the recognition: expressive therapies.

Factors that impeded the recognition of dissociation.

Therapist factors. It became clear that the primary assumption, *a lack of knowledge and training about dissociation leads to a lack of suspicion and misdiagnosis*, was a major factor. At the time of the initial intake, I had no knowledge about dissociation in children. As a result, dissociation was not considered in the *differential diagnosis of symptoms*, and I gave a *more common diagnosis*.

A lack of knowledge about dissociation resulted in the omission of another key factor during the intake process: a thorough trauma assessment. Although the intake form

asked about violence or trauma, it specifically inquired about the experience of emotional, physical, or sexual abuse, or domestic violence. *I had a lack of knowledge* of the meaning and categories of trauma associated with dissociation. Therefore, I did *not ask the right questions*.

I also did not have all the information I needed at the intake. Sometimes information is not available. Sometimes new information is found out later. The therapist needs to ask for all pertinent information and *obtain records* from other professionals immediately. I did not do that in this case.

Another factor noted that impeded the diagnosis is *skepticism*. After I was referred a child with a dissociative diagnosis, I still remained *skeptical* for a considerable period of time. First, I questioned whether the diagnosis of dissociation in children, especially the existence of other personalities or parts, was real.

Another factor that affected the diagnostic process was a *lack of personal experience*. This contributed to a *lack of confidence* in my diagnosis and a reliance on the psychiatrist's diagnosis because I believed she had more knowledge and experience. My *lack of confidence* was also reflected in my uncertainty in my diagnosis even after seeing the score on the Child Dissociative Checklist, and in the statement I made in the second email to the psychiatrist: "I don't want to 'make something that isn't there', but I still think she is dissociative." In this instance, the controversy in the literature accusing clinicians of iatrogenically creating dissociative disorders in their clients added to my *lack of confidence*.

Parent factors. Emily's AM also had a *lack of knowledge* about trauma, and did not report any trauma at the intake session. In addition, she *omitted other information* at

the intake session. Emily's AM did not report that she had been hospitalized for two weeks when they first got her until several sessions later. This illustrates the importance of *ongoing assessment, asking the right questions, and gathering information from multiple sources*. This may also raise the therapist's awareness that caregivers *may not be accurate historians and/or may not be reliable reporters*.

A lack of consistency in counseling sessions may also impede the diagnosis. The more often the therapist gets to see a child, the more they are likely to recognize if there is a switch in the child's normal behavior, affect, or demeanor. Large gaps in counseling also make it difficult to establish rapport and safety, and may interfere with the level of trust and disclosure. My review of the chart indicates most sessions were one week apart. However, there was a three-month period in which I did not see Emily: There had been a one month gap in sessions, and then I had met with her parents to provide some training to them. When I had my next session with Emily, I noted in the chart, "re-established rapport.... Emily was happy to see therapist; confused about where she [the therapist] had been."

Other professionals. Emily's treating psychiatrist also exhibited the theme, *a lack of knowledge and training about dissociation leads to a lack of suspicion and misdiagnosis*. She gave the *more common diagnoses* of RAD and ADHD. The psychiatrist's comment to Emily's AM that she "considers dissociative symptoms to be part of the RAD diagnosis" also displayed *lack of knowledge about dissociation*.

Comments by other mental health professionals also indicated the theme of *skepticism* that surrounds the diagnosis of dissociative disorders in children and impedes diagnosis. The treating psychiatrist appeared to be *skeptical* in her recorded note that the

“patient’s therapist, J. Reycraft, questions whether Emily might have Dissociative Disorder.” The presenter from the training on RAD made the comment, “we don’t believe in that” indicating *skepticism*.

A final factor that impeded the diagnostic process in this case is the *difficulty encountered in consulting with other professionals*. I attempted several contacts with other professionals that were never returned. One attempted contact was completed eight days later. A contact with the school psychologist was completed after several voice messages were left back and forth.

Factors that advanced the recognition of dissociation.

Therapist factors. Several factors also helped to advance the recognition of dissociation in the case. A significant occurrence was the referral of my first child client with a dissociative disorder. This *introduction to the existence of dissociative disorders in children* prompted me to *increase my knowledge and training*. Learning about the background, theories of the development of dissociation, and assessment components was a first step toward consideration of dissociative symptoms and disorders. Reading descriptions of symptoms in cases in the literature increased my understanding and awareness.

Consultation with the referring psychiatrist was an important factor as I was gaining knowledge about dissociation. As I increased my understanding of the referred child’s dissociative symptoms through *personal experience*, I became aware that Emily had several commonalities with the other child, e.g., lying, regressive behaviors, destructive behaviors, and changing abilities. I also recognized that *treatment and medication were not being effective*. This became visibly evident when Emily’s AM

called me two months after this referral to describe the incident that occurred when she woke her up and found she had defecated and wiped it all over her clothes and comforter. These two factors prompted me to *review the chart and other records*.

Now that I had an *increased knowledge*, I was able to recognize Emily's severe *trauma history*: neglect, abuse, being separated from her birth parents and moved from place to place, poor attachment, hospitalization, and rejection by her siblings. I now knew that *trauma* at a young age is highly correlated to dissociative disorders (Chu & Dill, 1990; Coons, Bowman, & Milstein, 1988; Drajer & Langeland, 1999; Putnam et al., 1986; Ross, Norton, & Wozney, 1989; Zlotnick, Shea, Pearlstein, Begin, Simpson, & Costello, 1996). This *knowledge raised my suspicion* that she may be dissociative and led to an *ongoing assessment* of symptoms.

I now began to *ask the right questions* of Emily's AM about her symptoms, e.g., exploring for changes in personality and abilities. I had *increased knowledge about screening instruments* and administered the CDC (Putnam et al., 1993) to further assess symptoms. With increasing *experience and observations of repeated behaviors* such as Emily "turning her feet and walking on her ankles", her AM and I were co-partners as we began to *differentiate symptoms of dissociation*, e.g., switching and regressive behaviors. (See Emily's Assessment Chart in Appendix H.)

Parent factors. Parent factors that may help in the earlier diagnosis paralleled some of those of the therapist. As Emily's AM increased in *knowledge of trauma and dissociation*, she began to also *observe repeated patterns in behavior*. She became more attuned to the meaning of some of Emily's behaviors, e.g., chewing the inside of her mouth when she became anxious.

Emily's AM brought in a video clip of her behavior. The video clearly showed regressive behaviors, switching behaviors, and rageful behaviors that increased the therapist's certainty of a dissociative disorder.

I also noticed a pattern of *inconsistent parental support and perceptions* in statements made by Emily's AM, e.g., "so frustrated; I feel more relaxed, more understanding of her; I don't think I can do this anymore." In addition, the AM reported several times that she was in tears. These behaviors may be indicators of attachment problems. The changes in her acceptance and rejection of Emily, and in her ability to cope, may send mixed messages to Emily. She may form changing internal working models (IWM) whereby she and her AM may be perceived as persecutor, victim, or rescuer (Karpman, 1968). This may create a disorganized attachment in which Emily does not know if it is safe to approach her AM or not (Liotti, 1999, 2009). Liotti's model posits that a disorganized attachment increases the likelihood of dissociation.

Other professionals. *Consultation* with an expert in dissociation provided confirmation of the diagnosis. This is an important factor as The Codes of Ethics of the various mental health professions require clinicians to obtain consultation and supervision when practicing in new areas. This *consultation* also *increased my confidence* in my ability to recognize symptoms of dissociation.

Expressive therapies. I observed Emily express several possible symptoms of dissociation in her play, e.g., a puppet show with a dog who does not know about another dog with the same name, a book about an imaginary friend, and scratching a name out, may indicate alters. While these play themes and other expressive therapies may support

the recognition of dissociation, they cannot be considered conclusive evidence of a dissociative disorder on their own (Malchiodi, 2005). This is an area for further research.

Tyler

Tyler is an 11 year old Caucasian male with sandy brown hair, blue eyes, and a husky build. He was diagnosed with a somatic dissociation after one year. I began seeing Tyler eight months after I was referred my first dissociative child. It was ten months after I began seeing Emily again, and six months since I first suspected she was displaying dissociative symptoms. I had just ordered the book edited by Wieland (2011), and within weeks I would learn about the ISSD (2004) Guidelines.

In the beginning. Tyler was in fifth grade when his AM was referred to me by his school guidance counselor. At the initial intake appointment, she reported the teachers said he was “constantly touching and aggravating other students,” he cursed, and he had cried yesterday in two classes. She stated his math teacher called on behalf of all his teachers, and told her they “want to put him on a 504 Plan.” She expressed concern that Tyler “will take the blame when he didn’t do it.”

Tyler’s AM reported she was concerned about his behaviors at home as well. When asked to describe the situation/symptoms for which she was seeking help and what she would like to accomplish on the Child/Adolescent Intake form, the AM responded, “I want to be sure or I would like Tyler to [be] happy most of all. Behavior with sister and school.” On the Symptoms Checklist, Tyler’s AM checked off every symptom that would normally indicate ADHD: careless, can’t pay attention, doesn’t listen, doesn’t finish things, disorganized, often loses things, easily distracted, often forgetful, restless/fidgety, can’t stay in seat, can’t play quietly, talks too much, answers before question is finished,

doesn't wait turn in conversation or games, acts without thinking, and poor school performance.

Tyler's AM also checked off other items that were indicative of oppositional behavior, but added qualifiers to many of them as if to minimize the seriousness of the symptom. For example, she marked "lies when caught red-handed," but wrote "seldom" next to it. She checked often "argues with adults," but added "he's learning." Next to "disobeys rules," she added "sometimes." She did not check "destroys property," but she wrote "not on purpose" next to it. Other items checked included blames others, easily annoyed, angry/resentful, and spiteful. She indicated some symptoms of low self-esteem or possible depression, e.g., has few friends, feels worthless, loss of energy/tired, unable to sleep well. In addition, she reported that Tyler had nightmares and enuresis frequently at night and that he complained of frequent stomachaches.

Tyler resides with his AM and adoptive father (AF), both age 50, and their biological daughter, age 9. Tyler's adoptive parents (AP) have been married for 15 years; his AM added, "and going strong" on the Child/Adolescent Intake. Both AP have been married once before, and both have attended technical college. Tyler's AF is self-employed. His AM works from home and helps with the business.

Tyler's AM informed me that he came to them as a foster child when he was six months old. She reported that he continued to have supervised visits with his birth parents (BP) for the next two years before their parental rights were terminated, and he was legally adopted by them. Tyler's AM reported that neither he nor their biological daughter knows that he is adopted. She stated that she and her husband had decided to

adopt after being unable to have a child of their own. Even though they had a biological child after adopting Tyler, his AM stated they love both of them the same.

Tyler's AM did not provide much information about his prenatal or postnatal history. She reported that he weighed 7 pounds, 12.5 ounces at birth, and that his birth mother (BM) smoked and drank, but she was not sure about anything else. She did not know at what age he held his head up, but she indicated that all other developmental milestones were met within the typically expected age ranges.

Information provided by Tyler's AM about his birth family's history was also scarce. Tyler's AM reported on the Child/Adolescent Intake that his BP used alcohol/drugs. She did not know of any legal involvement, suicidal behavior, or mental health history of his birth family. She stated that there was a history of physical abuse and domestic violence, but she was unable to expound on this.

Tyler's medical history was remarkable for several items. He had tubes put in his ears when he was approximately one year of age, and he also had a circumcision due to chronic infections at age 2. His AM reported he has problems with constipation, and has had continued problems with enuresis at night. She stated Tyler goes to bed at 8:00 p.m. on school days and wakes up at 6:00 a.m.; she usually wakes him up three times at night to go to the restroom. His AM stated she is taking Tyler to see the urologist next week for bedwetting. She reported that he still tosses and turns at night, and he sleeps in a fetal position. She expressed that Tyler had gained 10 pounds in a 30-day period due to medication he was taking; however, he has once again lost the weight since stopping the medication.

His AM reported he began taking medication for ADHD at age 6. She stated the medication was prescribed by both his neurologist and pediatrician. She stated that the medications “ran the gamut”, i.e., Focalin, Intuniv, Concerta, Straterra, etc. She reported none of them worked until a few months ago when he was prescribed Abilify. She noted there was a significant change in his behavior, and “everything we ever taught him went into effect – even putting the seat down on the toilet.” She reports it did not change the bedwetting though. Tyler’s AM stated he was on this medication for less than a month when it began affecting his liver and had to be stopped. She stated that she needed to schedule an appointment to have his liver checked again. Tyler has not been on any medication since that time. His AM stated that she had made an appointment at the community mental health agency to see about medication but had to cancel it.

On the Child/Adolescent Intake, Tyler’s AM wrote “NO” when asked if he had received counseling in the past. However, upon further prompting, she informed me that he had seen two previous therapists. She stated he went for six counseling sessions when he was around 4 or 5 years old to help with his behavior. She stated he went to another therapist 4 years ago for 7 or 8 visits, but it was not helpful. Tyler’s AM stated she was unable to remember the names of the therapists.

Tyler’s AM denied any history of violence or trauma. When asked on the Child/Adolescent Intake if he had experienced emotional, physical, or sexual abuse, or had witnessed domestic violence in their home or the home of others, she wrote “NONE – we came close to losing our home – some things the children heard, raising of voices.”

Tyler’s AM indicated that both parents are involved in discipline. She reported that the discipline used is “mostly restricted of items, extreme measures spanking.” She

noted that he “has not been spanked for several months.” Tyler’s AM stated that the discipline used is effective “for a while.” She stated that the parents do not agree on discipline “all the time.”

Tyler’s AM reported that he attended a Christian pre-school. She stated “I don’t think so” when asked if he had a learning disability. He reportedly did not have an Individualized Educational Plan (IEP) and had not repeated, skipped, or had any interruptions in his education. His AM reported she was “somewhat” happy with his school performance, but she expressed concern that his “grades have been dropping each year.” She indicated that Tyler did not get along well with others; she stated he only had one friend, and “they mostly play video games.” His AM noted “he tries so hard.”

Tyler’s AM reported that he likes to read and on weekends play video games. She stated “I have to make him play outside.” His AM indicated he watches one half hour of television per day during the school week, no video games, and one hour of computer time. On the weekends he is allowed two hours or more of each. She reported his strengths are “determination, smart, funny, loving with his parents.” She noted that he had participated in tae kwon do in the past, and “it was good for him,” but they had to withdraw him due to the change in their finances.

Tyler’s AM reported that she was “raised in the church,” but they were not attending any church at this time. She wrote, “He loves the lord he was baptized at camp” on the intake form.

Tyler’s AM indicated that he also has an aunt and uncle who are significant people in his life, as well as some older cousins. The Child/Adolescent Intake form

inquires about the child's support system by asking who he usually goes to when he needs to talk. Tyler's AM indicated "mom" in response to this question.

At the end of this session, I gave Tyler's AM the Conners 3rd edition (Conners 3, 2008) parent form to complete, as well as three forms for Tyler's teachers. The Conners 3 is a normed screening instrument that helps to assess for Hyperactivity/Impulsivity, Inattention, Executive Functioning, Learning Problems, Defiance/Aggression, and Family/Peer Relations. It also includes scales that coincide with the DSM-IV-TR (APA, 2000) symptom criteria for ADHD, Oppositional Defiant Disorder (ODD), and Conduct Disorder. A Conners 3 Global Index (Conners 3GI) scale is included to assess the degree of psychological difficulty a child may be experiencing. Some of the items are also used to screen for depression and anxiety.

Hear hoof beats... think horses. Tyler was accompanied by his AF and sister for our first session the following week. He appeared relaxed and answered my questions honestly. He told me he didn't know why he was here, but he had some problems at school: kids tease him, staying in his seat, and blurting out answers. He also told me he is "the smartest in his class." Tyler completed the Conners 3 (Conners 3, 2008) self-report form at this session.

At our next session a week later, and in a telephone call the day before, Tyler's AM informed me she had been out of town the previous week. The schools were doing testing and Tyler "was in trouble every day and had to do silent lunch." She reported she had to reschedule the urologist appointment since she was gone. She stated Tyler had an appointment at [mental health center 1] the next day. She expressed concern that Tyler has had stomachaches every morning for about a month. .

At this session, Tyler completed a Kinetic Family Drawing (Burns & Kaufman, 1970). Clients are instructed to draw a picture of themselves with their entire family doing something. It is a projective technique used to assess the client's perception of his family and the family dynamics. Tyler drew a picture of his family watching television. Oster and Crone (2004) identify this as a common action depicted in these drawings that may indicate "a possible lack of direct communication or ... an enjoyment of just being together" (p. 119). The people in Tyler's drawing did not have faces or bodies. My notes hypothesized that "the people do not have faces possibly because facing the TV., possibly not comfortable drawing faces, possibly hiding emotions or not aware of them."

Once all the Conners scales (Conners 3, 2008) were completed, the raw scores were converted to T-scores and percentages. All of the reports were assessed for validity. All five reports indicated a consistent response style. Two of the teachers' reports indicated possible negative response styles. However, their scale scores were consistent with those completed by the third teacher and Tyler's AM, so all scores were considered to be valid. Tyler's AM and all three teachers' ratings were very elevated for Inattention, Hyperactivity/Impulsivity, Executive Functioning, Defiance/Aggression, Peer Relations, the Conners 3GI, and DSM-IV-TR scales for ADHD Inattentive, ADHD Hyperactive-Impulsive, and Oppositional Defiant Disorder. Two teachers' and Tyler's AM's ratings were also very elevated for the DSM-IV-TR scale for Conduct Disorder. Only one teacher's rating indicated a very elevated score for Learning Problems. In addition, the results of all three teachers and Tyler's AM indicated a need to screen for anxiety and depression.

Tyler's scores were very elevated for Hyperactivity/Impulsivity and DSM-IV-TR ADHD Hyperactive-Impulsive; elevated for DSM-IV-TR Conduct Disorder and ODD; and high average for Defiance/Aggression. Tyler's ratings were average or low for Inattention, Learning Problems, Family Relations, and DSM-IV-TR ADHD Inattentive. I determined that some of Tyler's responses in these areas may have been minimized due to the discrepancy with the other reports. The self-report form does not include Peer Relations or the Conners 3GI. Tyler's results did not indicate a need to screen for depression, and only one item indicated a need to assess further for anxiety.

I contacted Tyler's AM to request to meet with both parents without Tyler present. Tyler's AM informed me they had gone to the appointment at [mental health center 1], but did not plan to pursue further visits because they did not want Tyler on medication. She called me back later that day to express concern that Tyler "gets up at night and pees on the carpet and the wall." She reports he did it last night and two other times in the last two months. She stated she does not believe he does it on purpose. He will have an appointment with the urologist next week.

I met with Tyler's parents to discuss the assessment results. Although Tyler's ratings were in a lower range than his teachers and parent, they all indicated the likelihood of ADHD, and it corroborated with the diagnosis his AM reported. They all appeared to indicate ODD and Conduct Disorder as well. However, Tyler had presented as cooperative and pleasant in his first two sessions. We formulated a treatment plan based on the diagnosis of ADHD with rule outs for ODD and Conduct Disorder. Tyler's AM reiterated that they "do not want Tyler on medication due to concern about physical harm to his body." I recommended they find an activity to help with Tyler's social skills.

The school year is ending. For the next six sessions, I alternated between seeing Tyler and his parents. I provided psychoeducation about ADHD and parenting to Tyler's parents. I explained the need for more frequent and immediate feedback and consequences, breaking tasks down, shaping behavior, and being consistent (Barkley, 2000). We discussed a behavior system; rules and consequences; differences in parenting styles and expectation; and effective communication skills. They were pleasant to work with and participated well in sessions. They were "open and cooperative." I noted they appeared to be aware of difference in expectations, the need for consistency, and the need to learn other behavioral and discipline strategies.

I worked with Tyler on anger management strategies and taught him the ABCs (activating event, belief, consequence in terms of actions or emotions) of Cognitive Behavioral Therapy (CBT). He indicated in an earlier session that he was not aware of physiological changes when he became angry. He appeared to get in trouble at school when other students annoyed him; he showed me a behavior form from the teacher for telling another student to "shut up" and using other "inappropriate language" at one session. In a session with his parents, his AM reported the teacher stated he was aggravating another student and starting to show anger; when the teacher confronted Tyler, she states he denied the behavior. His parents reported in another session that he had become angry at home and pushed past his AM. She stated "it is difficult to get him to focus/think when he is angry." Tyler indicated that he didn't get "sad, sad at school – just bored." He said that sometimes he cries when he gets angry. Tyler appeared to understand the concepts we discussed, but he had poor impulse control.

During this time, I consulted with the guidance counselor and two of his teachers. Tyler's AM had provided copies of agenda pages to highlight some of the problems he was having. One teacher wrote:

I was not able to write a note in Tyler's agenda yesterday because he said he didn't have it. He was sent to timeout and did a behavior form. He was even uncooperative with the timeout teacher. He was completely disruptive to the point that I couldn't conduct class. Tyler has HW on M, Tu & Th each week. He has not had a good week at all.

Another teacher commented, "Tyler has been very disruptive today during class. I have talked to him numerous times and this has not seemed to help. Tyler was asked to move to another desk + on his way he mumbled + talked back." A third teacher remarked, "Tyler will not stop talking, moving his desk. He is not doing his work. He is talking back to me when I correct him."

In our conversation, the teachers expressed that they "don't believe Tyler wants to misbehave; he cannot control his impulses." They stated that he also really wanted to belong. As the school year was drawing to a close, they suggested that he get involved in a group at middle school where "he can have an identity and a sense of belonging."

By this time, it was becoming apparent that Tyler's AM had some memory problems. She had missed two appointments before we even completed the initial intake session. She had forgotten three more appointments before the 12th session. I discussed her memory problems with her twice and recommended she rule out a medical cause. She expressed she "never used to be this way."

Days of summer. At the next session with Tyler's AM, she reported that friends and family had noticed a "major improvement." She stated, "Tyler had more patience and we haven't seen his temper since school got out. He is listening and focusing more, considering other's feelings, opening doors for others, not wetting the bed, and not lying." She stated that "even last summer, he was not this good, so it's not just because school is out." Tyler's AM reported he was in karate three times a week. We discussed attunement between a child and mother. Tyler's AM demonstrated increased insight in how her interaction and responses impact Tyler's emotional states. We created behavior charts for both Tyler and his sister.

I met with the whole family in a session to address communication skills. We discussed interrupting and perception checking. We used an incident when Tyler was angry as an example of differing perceptions; he perceived the level of his anger to be a 3, while his sister perceived it to be a 7 on a scale of 10. At this session Tyler had difficulty not interrupting, laughing during the game, and moving the stool with his foot.

I continued using CBT to work with Tyler separately, and with his AM, on identifying ABCs in situations reported and beginning to recognize automatic thoughts and cognitive distortions. We also continued discussing and practicing using communication skills when angry. Tyler and his AM appeared to understand the concepts taught.

Progress over the summer was varied. The family arrived for one appointment 30 minutes early; a colleague informed them I was in a session so they left. Homework was often not completed. The family did not have good follow-through with the behavior chart. They either did not complete it, or did not track it for each day of the week. Tyler's

AM stated they “want to do the checklist, but they are always on the go.” She also expressed that they “need help with rewards that don’t involve the parent’s time all the time.” I noted that Tyler’s AM appears to have difficulty prioritizing.

In the sessions before school began, Tyler’s AM stated they had decided “no matter what happens, they do not want Tyler on medication.” Tyler’s AM reported behaviors were better at home, but she was concerned about the school environment. She noted some improvement in his impulsive behaviors such as interrupting and reported fighting with his sister had decreased. She stated he lied about the amount of time he played his video game. She also expressed concern about his hygiene; she states he told her he forgot to wash his hair, but she doesn’t believe him. I noted that she appeared to be consistent in applying consequences.

The cycle repeats. Three weeks passed. Tyler’s AM reported in a phone call that Tyler was doing well with school so far. However, she added, “We have to keep on him for everything.” She stated he was starting to complain about some of the kids, and she wanted to look into virtual school. She reported she lost her calendar when she was sick. I again expressed concern about her memory and encouraged her to rule out a medical cause.

At our appointment the following week, Tyler’s AM reported he had no comments about negative behaviors in his agenda. However, she expressed concern that he was not getting his work turned in on time and misplaced it. She stated his backpack was disorganized. We discussed letting Tyler own the problem. His AM reported she doesn’t have to “stay on him” like she used to.

We also reviewed the treatment plan at this session. Tyler's AM reported improvement in demanding behaviors, interrupting, and not waiting. I inquired about Tyler's socialization at school. He reported he ate lunch with two other boys. I asked Tyler and his AM to complete a social skills checklist indicating their perception of Tyler's negative and positive social skills. Tyler's AM checked that Tyler engaged in 18 out of 25 negative social skills, while Tyler checked off only 5 out of the 25 items. Tyler's AM checked off only 4 out of 22 positive social skills, while Tyler checked off 18 out of 22 of the behaviors. Tyler appeared to be unaware of his negative social behaviors and other's perceptions.

One week later, Tyler's AM reported he had been sick for the past week. She states they took him to the ER due to pain spasms. She reported the doctor could not tell what it was; it may have been a virus. Tyler reported he felt "groggy." He stated he is having trouble falling asleep. He said, "When I get home, I'm not relaxing." When asked, Tyler reported he went to bed at "6:00 or 7:00."

Tyler's AM expressed frustration again at this session that Tyler was not completing his homework or emptying his backpack. She reports she feels "he is being lazy. All he wants to do is play Hot Wheels and videos." I worked with Tyler to identify obstacles to completing his work and strategies to overcome them. I asked him to create a sand tray that represented how he felt about school. I noted in the chart his "sand tray indicates concrete thinking. He created a scene of him waking up, eating, and going to school. It appears Tyler may not have [an] accurate perception of bed time, or that he is going to bed too early which may be the reason he is having difficulty falling asleep."

At the next session I worked with Tyler's AM on strategies to help him by using more immediate reinforcement, setting up a schedule, using a timer, and implementing consequences. She was open to the behavioral strategies, but I advised her that if they are not working, he may need medication. Tyler's AM expressed she does not want to put him on medication.

Tyler's AM called the next day. She was upset and discouraged. She reports, "I'm done. He lies all the time." She states he lies about not having homework when he didn't write it all down. He lied about downloading pictures on his cell phone. She reports his teacher wrote a note saying she knew he did a paper in class, but he didn't turn it in. She repeated again her desire to avoid medications. I recommended she contact the guidance counselor to see if a meeting was needed.

My mind began turning over Tyler's AM's comment that "he lies all the time." When she called back a few days later to report she had not heard from the guidance counselor, I discussed with her that she was "lying" by not telling Tyler about his birth circumstances, and we discussed the risks of telling.

Over the next three months, the reports were similar. I received a telephone call from Tyler's AM. She had received an email from a teacher that he was "making gay slurs; almost got in a fight, throwing things." She reported Tyler told her he "can't control his emotions." His AM stated he "looked ready to cry" when he said it. She again expressed fear about medication due to their experience with the previous prescription affecting his liver.

I attempted to call the school guidance counselor and left a message with her receptionist. In the meantime, I had a session with Tyler's AM. She reported she was

changing his karate to more self-defense due to “bullying.” She reported she feels like she is “doing it by myself” as she and father have different parenting styles. She reported she rubs Tyler’s back in the middle of the night when he can’t sleep. She stated she has not seen any homework and he has not brought her anything to sign.

After a couple days of phone tag, I was able to speak to the guidance counselor. She reported Tyler had had five disciplinary actions in the last three weeks. He had two As, three Bs, a C, D, and F. She reported Tyler had a 504 Plan in place that had been updated six months ago. We scheduled a school conference that took place two weeks later.

The school conference produced the following comments from teachers:

- “Tyler won’t put his book down...doesn’t turn in assignments.”
- “He struggles socially. He is usually reading....”
- “He is a ‘loner’ – no problems with others around him....He does well on tests (‘very smart’)/things done in class; sometimes he doesn’t finish.”
- “Tyler has a problem turning in work he takes home.”
- “He will roll his eyes, but is not verbally rude. She reports an issue with reading his book.”
- “He zones out and doesn’t follow instructions.”

One teacher reported he turned in his homework. She reported he unloaded his backpack on the desk next to him. She states if he only has to be told to “stay focused” one time, he gets a gold ticket or candy.

There was a one month gap of time between the conference and the next appointment due to a holiday and my attendance at my first ISSTD conference. During

this time, I had confirmed the diagnosis of DDNOS for Emily. When I met with Tyler's AM, she reported she had scheduled an appointment at [mental health center 1] in two weeks. She stated he was failing his classes. However, his AM reported she "is not giving up." Tyler rated his level of happiness a 9 out of 10. He states he "feels like quitting, but he's not giving up." He reported he was responsible for the problems he is having. Tyler reported he felt successful at his aunt's house and at tae kwon do. I noted:

It appears that Tyler really wants to please his parents and do well. He appears to be happy in spite of his difficulties. He displays knowledge of appropriate social behaviors. It appears his impulsivity interferes with his ability to be successful in social relationships and academics. Medication may benefit him.

Tyler's AM forgot the next two appointments. She reported she had cancelled the appointment at [mental health center 1] due to illness. She states she has not rescheduled it because she is still leery of medications. Tyler's AM reports she has gotten several phone calls and emails from his teachers. They report he is "tuning out," and he brought legos to school. Tyler's AM reports his bedtime is 8 p.m. She stated he is not doing any work. She also reported that she lost the paper to get on the parent portal, and she is embarrassed to call the school again. I encouraged her to go to the doctor for herself and addressed her concerns about medication for Tyler. I also addressed developmentally appropriate bedtimes for middle school aged children. She committed to scheduling another appointment at [mental health center 1].

Almost a month passed before our next appointment. Tyler's AM continued to oscillate about medication and her perception of Tyler's behaviors. She reported Tyler would have an appointment at [mental health center 1] in three days. She has accepted

that he may need medication. His AM reported “he has given up. He is not doing work, lying, won’t listen, does his own thing, doesn’t care.” She reports his AF took him for a “talk in the closet – one pop – talk some more.” She stated they told him “you are not contributing to the family; it’s not all about you.” Tyler’s AM added, “He totally ignores his teacher when she is talking and reads his book.” She stated nothing is working. She wanted to use “shock therapy -- taking away everything, spanking, thought of telling him he was adopted.” Yet, she also stated she believes Tyler “wants to do good, to love and be loved.”

Tyler reported he attended a weekend camp. His AM stated he had difficulty with some of the kids socially. Tyler expounded, “Some kids wanted to beat me up.” Tyler stated he got a referral last week for not having his i.d.; he has gone through 20 i.d.s. In addition to examining his behaviors and parent interventions, we discussed the lack of progress due to illness and infrequency of sessions with Tyler and his AM.

Tyler’s AM was going to schedule the next appointment after Tyler had gone to [mental health center 1] and gotten medication. However, his AM called to report the medication appointment would be a month after the first appointment. She stated Tyler was staying after school two afternoons for tutoring and to complete homework. She reported he was angry about it. Tyler’s AM stated he was crying at dinner, “I know why you’re doing this – so you can get rid of me!”

The next four months. Tyler received good reports in his agenda for the next two weeks. After that his academic performance began dipping again until he and his AM both reported he was failing.

In the two weeks that Tyler was doing well, his AM questioned the need to keep the appointment at [mental health center 1] for medication because Tyler appeared to be improving. She continued to struggle with her fear of medication. After further conversation, she acknowledged that even though he was improving, he was still not functioning at a level similar to his peers.

Tyler was prescribed Clonidine when he went for his appointment a few weeks later. Shortly after, however, his AM stated it was not working. The medication was not working. That was the same thing I heard with the other two dissociative children I was working with.

I had enrolled in the ISSTD online course at this time, Professional Training: Assessment and Treatment of Traumatized Children and Adolescents with Dissociative Symptoms and Disorders. The course began with background about theory and neurobiology and then moved into assessment. Course participants were also introduced to the ISSD (2004) Guidelines at this time. It seemed that I needed to read and hear the information about dissociation repeatedly in order to remember to consider it. I realized I was missing information.

I faxed a release for information to Tyler's neurologist requesting records and to the psychiatrist at [mental health center 1]. I spoke with the psychiatrist's nurse. I informed her that the medication was not working and provided my number for the psychiatrist to call the following Monday. I informed the nurse that I had requested records from the neurologist and that Tyler was having difficulties in school.

Medication history. The neurologist faxed records that dated back approximately five years. As I began reviewing them, I noticed several things:

- There was a gap in visits after the first year and 10 months; the neurologist had noted “lost to follow up” for a five month period. After this one appointment, he did not see Tyler again for the next two years and three months; the notes again stated “lost to follow up”.
- Other notes indicated that Tyler’s AM did not bring report cards when asked three different times.
- She did not follow through on obtaining recommended counseling for Tyler.
- At his first visit, the neurologist gave the diagnosis of ADHD Inattentive and ordered a sleep deprived EEG. The next exam note indicated the EEG was abnormal. The neurologist stated Tyler was at increased risk for seizures, but since he had never had a seizure, he considered it “incidental” and would not treat for it. After that visit, he consistently gave a diagnosis of ADHD Combined and ODD. After the first gap in visits, he added the diagnosis of Sleep Disorder and History of abnormal EEG. Another EEG was ordered and monitored over a 20 hour period; the results were normal.
- Medications up to this point had included Focalin, Vyvanse, and Strattera. The neurologist now prescribed Abilify.
- Three weeks later, the neurologist’s note indicated that Tyler’s AM reported “this medication worked better than any medication he had been on in the past. His focus and behavior were improved. She felt he had his old personality back.” However, Tyler also had several “side effects including a stomachache, burning in his back and the top of his mouth as well as right arm pain and occasional headaches.” The medication was decreased.

- Two weeks later he added Nocturnal Enuresis to the diagnosis even though he had noted it being reported by the AM from the first visit.
- Two months later, the Abilify had to be stopped due to elevated liver function tests (LFTs). Geodon was tried, but cause increased depression and uncontrollable crying. The ARNP wrote the following:

I had a lengthy discussion with the mother about his past, being adopted and the abandonment issues he faced as a baby. He was in and out of foster care. I have advised her to seek the care of a child psychiatrist, referral was given. The school has grown tired of dealing with Tyler due to his behavioral outbursts.

I made a mental note to ask Tyler's AM about his early experiences as the records indicated "possible reactive attachment disorder." This note was approximately ten months before I began seeing Tyler. His AM had not taken him to a psychiatrist prior to seeing me, and had only gone back to the neurologist one more time a month later.

The neurologist's records noted repeatedly, "There is no evidence of hyperactivity, impulsivity or lack of attention span." I began to question the diagnosis. If Tyler was really ADHD, I wondered whether those behaviors would have been displayed during at least one visit over the course of those five years.

Back to the present. Three weeks after Tyler's AM reported the Clonidine was not working, she reported he had a "skin burning sensation" on and off the medication. I recommended she ask the doctor at her next visit the following week. Tyler's AM called me a week later after they had the return visit with the psychiatrist. She expressed disappointment and frustration with the doctor. She reports they left with "no new prescription, no appointment, nothing." She stated the doctor said she did not know what

to do because she didn't have the previous records even though the AM signed a release for the neurologist when she was there one month ago. Tyler's AM stated the psychiatrist said Tyler needed blood work; the AM stated she told her they did that the last time they were there. Tyler's AM expressed frustration that the psychiatrist asked her what she wanted her to do. Tyler's AM stated she will need to get a different psychiatrist.

Rising suspicions. At the same time that Tyler's AM had reported the Clonidine was not working, Tyler had reported he was failing four classes and passing four classes. He believed that his AM could have a conference tomorrow, and he could make up the work over the break. When I asked about how his academic performance might affect his future, he expressed that he "could do a business like his dad does."

Again, this was when I was completing the assessment portion of the online course, and realized I was missing information. Therefore, I met with Tyler's AM for the next session. It was two weeks later as she was ill the week before. I asked her about Tyler's early experiences as a follow-up of my review of the neurologist's records. She reported "his birth mother was at the bar drinking; his room was the size of a closet, he would cry, and no one would come." Tyler's AM reported when they first got him, "he would not look into our eyes, and would not hug." It appeared that Tyler may have had a diagnosis of RAD when they got him, i.e., he had pathogenic care and inhibited attachment. However, I noted that at this time "based on our discussion and my observations of Tyler with his AM, I do not believe that RAD is a factor in his behavior." I requested again that Tyler's AM bring his report card to our next session. Tyler's AM expressed concern that he was not on medication; however, she stated she did not notice a

difference with it. She expressed concern that Tyler is withdrawing from the family, and that he and his AF “do not connect.”

Tyler was brought to the next session by his AF. Tyler reported he had brought up some of his grades, although he did not know how he was able to do his work and stay focused. He stated he felt supported by his family and teachers. He felt that the medication had helped a little. When I mentioned the statement he made at our last session about “doing a business like his dad’s,” Tyler looked surprised. He didn’t remember saying that, and he stated, “I would never want to do that.” I asked Tyler if other people had told him things he did not remember. He replied, “Yes,” but he could not provide a specific example.

I called Tyler’s AM immediately after the appointment to discuss his amnesia for the comment he made. His AM reported he used to have seizures, but the last EEG approximately one year ago showed he “grew out of them.” She stated she would try to monitor any other episodes of forgetfulness. She added that Tyler would have his initial appointment at [mental health center 2] in two days.

The following week I met with the AM and AF. Tyler’s AM showed me a picture of Tyler when he was 2-3 years old with a cousin. She posited that he would not question being adopted because there was a family resemblance. Tyler’s AM reported he will not be able to see the ARNP for medication for another month. She stated she had spoken to the dean regarding some bullying activity at lunch. She stated Tyler didn’t want to go to school Monday. He told her the kids don’t want him to sit at the table at lunch. She stated he is worried about getting into trouble [at lunch]. Tyler’s parents reported he is lying frequently. They reported problems in the relationship with his sister. We also discussed

priorities and communication problems between the parents and family members. They agreed that they have all been experiencing stressors that have contributed to harmful patterns of communication. We planned to have a family session the next time.

A complicated world. At the next session, Tyler's AM reported they had applied to a charter school. She expressed concern about his report card, but she did not bring it with her. I engaged the family in an activity with the instruction to "create your world in the sand." The sand tray, shown on page 146 in Figure 5, appeared to be representative of the family dynamics, and they appeared to benefit from the increased awareness of them.

Tyler appeared to consume much of the sand tray, just as he consumed much of the family's time and energy and crossed boundaries. His AF commented, "Kind of taking up the whole world, aren't you buddy?" Tyler replied that he had to have a road, even if it was a dirt one. His sister commented that "Tyler has too much space." His AM stated, "He's out there and all over, but still together in his mind."

Tyler's sister appeared to be feeling unprotected and unable or unwilling to stand up for herself; she appeared afraid to jump into activities. This was indicated by a person skating over a ramp and a soccer girl [sister] watching him, thinking about doing it. She commented that Tyler had taken her miniature scooter and started playing. She indicated he was bothering her and her parents did not stop him. When asked if that happened at home, what would she do, she responded she "would have asked him to give it to her and told mom and dad."

Tyler's AF appeared to be hesitant, watchful of others and waiting for space during the process. He placed a "worker ant", a shell to represent the beach, and family

members in a section of the tray. He appeared to take his role of provider seriously. He indicated his family is important to him, but he is often on the outside due to his provider role. He stated, "This is my life. I try to give time."

Tyler's AM stated she found the process "stressful." In the beginning she made a comment, "I'm building my world, you build your own" when one of the family members put a miniature in her space. Tyler's AF corrected her that it was "our world" and looked to me for affirmation. Tyler affirmed him with "Yes!" I responded that they could decide.

A little later, Tyler's AM laughed as she said, "My world's complicated." Tyler agreed it was, to which his AM responded, "Where we gonna put our world sweetie?" Tyler made room for her. The family appeared surprised, as was I, when Tyler's AM included a baby that died [miscarriage] in her section of the sand tray. The family knew about this event, but I didn't.

A lot of the AM's behaviors made more sense in light of this information. The baby in the sand tray was not buried: It was an unresolved grief, alive in her mind. It may have explained her extreme level of fear that medication would damage Tyler physically. It may have explained why she was so hesitant to tell Tyler he was adopted; perhaps she was afraid she would lose him too. It may have explained why she babied him, e.g., rubbing his back at night, setting an earlier bedtime for him than for his younger sister.

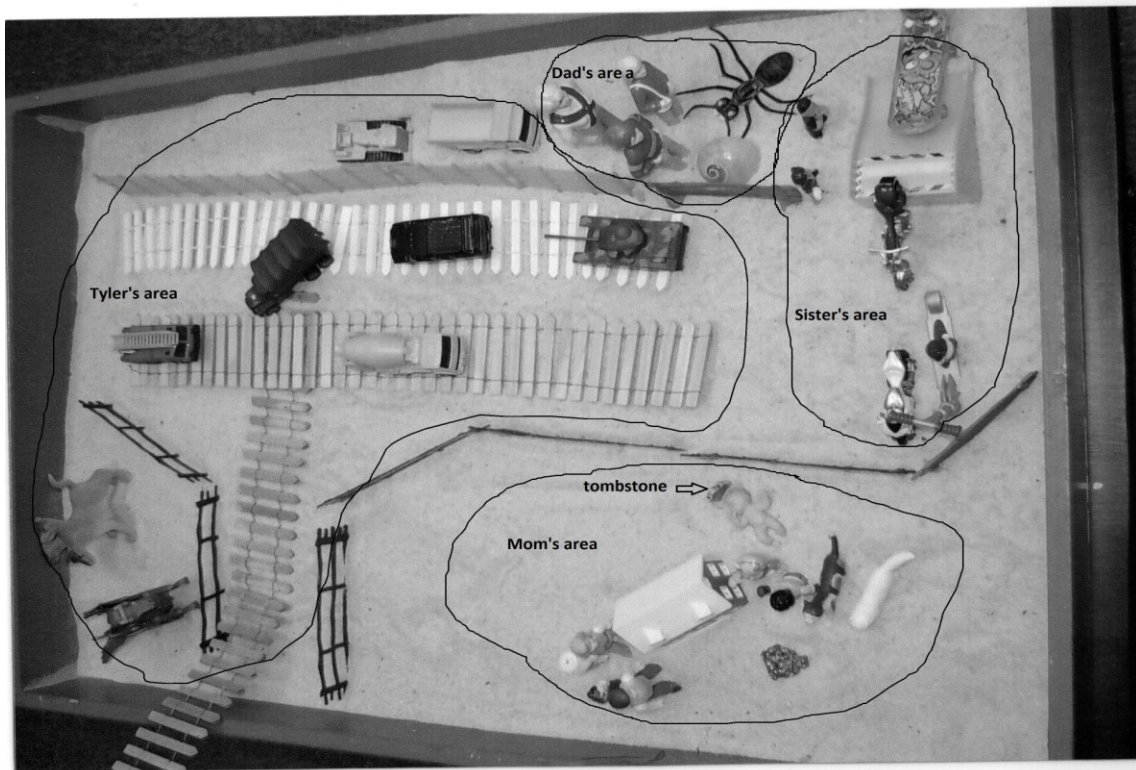


Figure 5. Family sand tray.

It's all adding up... or going nowhere. Tyler's AM made a further observation about the sand tray at the next parent session the following week. She stated, "We separate from each other. We're not united." We discussed other stressors that affect the family's ability to unite and their ability to parent effectively. Tyler's parents appeared to have increased insight into their different needs and perceptions of their relationship. However, they also appeared to be having difficulty matching their spoken priorities to their daily activities and decisions. Tyler's AM reported at this session that his interview with the charter school went very well. She stated that Tyler told the principal he really wants to go there because "I won't have to worry about anyone picking on me."

The next appointment with Tyler was 11 days later. I called his AM to remind him to bring a book we were using to his appointment that day. She replied that she had

forgotten the appointment, but they would be there. When they arrived, she reported that she had taken Tyler to the pediatrician one week ago because they “could not wait any longer for the appointment at [mental health center 2]. She reported the pediatrician prescribed Focalin. Tyler commented that he thinks he is not “annoying people too much.”

Tyler’s AM showed a brief video clip of an interaction between Tyler, his sister, and her friend. He was embarrassed and stated, “that’s not me. The camera makes me sound angry, but I wasn’t. I was messing around.” I discussed with Tyler how others may have a different perception, and how this may help him to see what they are seeing. He does not appear to be aware of the intensity of his emotions.

Tyler reported he lost his book. His AM expressed concern and frustration that he lies constantly. I asked Tyler to discuss reasons people might lie. He indicated there was a “good time” to lie and a “bad time.” I wondered to myself if he knew there was a “lie” in his family.

Tyler’s AM had forgotten when his appointment at [mental health center 2] would be. I asked her to contact them while I was in session with Tyler. When we came out, she had forgotten to call them. I asked her to call right then; his appointment was in three days. I noted that her forgetfulness may be a contributing factor in following up with Tyler.

Tyler’s AM called after their appointment at [mental health center 2]. She expressed frustration that the ARNP wanted to “do the same thing we’ve already done. She wants to try the same medications, i.e., increase the Focalin or give a release type of Focalin.” Tyler’s AM was also upset that the ARNP told her she needs the adoption

papers before she can prescribe medication. I told Tyler's AM that I would try to consult with another psychiatrist regarding his medication history. I inquired on the status of the meeting for Tyler's 504 Plan. She reported the school did not get back to her. She stated there are only 18 days of school left, so she is not going to pursue it. Tyler's AM reported he had looked for his book, but only for 15 minutes. I asked his AM if there would be a consequence for losing it. She agreed there should be a consequence, but she hadn't enforced one. She stated, "There was a time I was on him for everything." We brainstormed possible consequences together.

I consulted with the psychiatrist who had referred my first dissociative child immediately after hanging up the phone. I questioned whether Tyler really had ADHD if the medications were not working. He recommended finding out if the dosages were maximized or stopped due to side effects. The present records did not provide all the dosages or reasons they were discontinued. I called Tyler's AM and asked her to request the information.

The following week, Tyler's AM reported they did not complete their homework. She stated they were "busy" and she was "stressed." She reported Tyler has not gone to karate for the past two weeks. She stated he needed something for himself; he has just been "tagging along" with her and his sister. She expressed concern about fighting between Tyler and his sister. She stated he is doing "a little better" in school. The guidance counselor gave him two packets to work on. She stated she didn't understand how, but the F on his interim went to a 100. However, she said, he has an F in another class now. She reported he worked on homework from 4:00 p.m. to 11:30 p.m., stopping one hour for dinner. He only completed three papers in that time; he walked around a lot.

Tyler's AM reported the urologist said his bladder is fine at his appointment yesterday. She stated he prescribed medication to help. She stated the urologist said Tyler has a sleep disorder where he "sleeps too soundly." However, Tyler's AM stated his neurologist had done two sleep studies and said his sleep was normal. She reported he goes to bed between 8:00 p.m. and 8:30 p.m. She gets him up two or three times during the night, and he wakes up for school at 6:00 a.m. She stated when she gets him up, he is disoriented and doesn't know where he is. She stated, "He's starting to get rough with me" and has told her "you are getting on my nerves." In the morning, he does not remember. He tells her, "I wouldn't do that." She reported that, when he is awake, he does not mistreat her.

Tyler's AF also expressed frustration that Tyler is "always correcting me." As we addressed their concerns and discussed discipline strategies, he was able to see how this may be a learned behavior. Tyler's parents appeared to gain increased awareness of the differences in their discipline and the effect it may have on Tyler. They appeared to be aware that their priorities do not match their activities and that the AM's health is being affected by the stressors. I recommended again that she get a medical evaluation.

The next appointment with Tyler occurred two weeks later. In between appointments, his AM confused the date of one appointment, but called to confirm before coming, and then forgot one. She reported that the pediatrician had added Kapvay at night. Tyler remarked that, "Focalin is the first medicine I took." Tyler's AM reported he and his sister were still fighting "every time they see each other," but Tyler denied fighting "all the time." His AM expressed frustration that he continued to lie. She stated she has taken all electronics away, but he sneaks in to get them. She stated he lies about

the items on his checklist, and she cannot trust him to do anything she asks. Tyler's AM reported she lost papers regarding an appointment yesterday, but the agency called to reschedule.

I gave Tyler's AM the Child Dissociative Checklist to complete while I was in the session with him. I had been reading about the case of Ryan (Waters, 2011) and somatic dissociation. Tyler had enuresis with no medical basis. He'd also been taking ADHD medications for six years with no improvement. I also began to draw a correlation with Emily and the other dissociative child I had been referred as Tyler's AM continued to express that he lied all the time.

When I continued from our last session and asked Tyler to expound on a "good lie," he indicated he had a fear of losing his home and having to move. I explored a change like moving as an opportunity to reinvent yourself. Tyler stated that he liked himself because he is friendly, but he stated others are not friendly toward him. Tyler denied his AM's comment that he could not do the items on the checklist. He indicated that there is no consistency in the amount of time things are taken away. Tyler also indicated it was good to lie about feelings so others wouldn't make fun of him.

At the end of this four month period, I felt frustrated. I had asked Tyler's AM to bring the report card in several times, but she had not remembered it for the past nine sessions. This corresponded to the lack of follow through in completing homework and her forgetfulness of appointments. I discussed priorities at several sessions, with the AM separately, and with both parents together. Although they appeared to recognize that what they were doing did not match their perceived priorities or values, they also did not appear to be making any progress in changing. I had recommended Tyler's AM schedule

a medical evaluation for herself several times, but she had not followed through. I wondered whether Tyler's AM's inconsistencies and forgetfulness or the parents' different parenting styles were the reason he was not improving. However, his sister seemed to be doing well, so I determined their parenting was good enough (James, 1994).

The turning point. The Child Dissociative Checklist (Putnam et al., 1993) was the turning point. Tyler's AM's responses totaled a score of 13; a score of 12 or more indicates a need for further assessment for a dissociative disorder. Items marked as "very true" included:

- Poor sense of time
- Marked changes in abilities
- Difficult time learning from experience
- Continues to lie when the evidence is obvious
- Sleepwalks frequently

The following items were marked "somewhat or sometimes true:"

- Trance-like states
- Rapid changes in personality
- Rapid age regressions

Tyler's AM also indicated that he "lacks awareness of injuries." She stated he broke his wrist, and didn't complain. She said he doesn't "make a big deal about anything." She also reported he had an ear ache when he was younger; the drum burst, and he never said anything till the end.

Looking back. I reviewed the chart and the adoption records. I discovered that Tyler had actually been called by a different name for the first two years of his life. This

reminded me of the case description of Dalma (Baita, 2011), who was called by two names, presented in the literature review in Chapter Two.

The records indicated that Tyler's birth mother had a mildly retarded level of intelligence. She was functionally illiterate with a functional mental age of 11 years. The report stated that his birth father had a "defect to his skull" and currently has an artificial plate in his skull." This genetic defect was passed on to several of his children. His psychological evaluation indicated he had low average intellectual functioning.

According to the report, Tyler's birth mother became upset with the birth father and her sister because they were having a relationship. She left the home with Tyler and stayed with another couple when he was four months old. One week later, she left the house at 3:00 a.m. to go with her boyfriend. An investigator found the birth mother and Tyler at a motel. The birth mother stated she left to go on a date and thought taking Tyler with her was good parenting. "When the mother was asked when Tyler was last fed, the mother produced two bottles of curdled formula from the car seat that the baby had been in all day. The investigator noted that the diaper and car seat were saturated with urine." The Department of Children and Families sheltered Tyler as a result of neglect. His leg was x-rayed that day for a swollen red area on his right thigh. The report stated "the x-ray revealed nothing remarkable." Tyler remained with the shelter parents for approximately seven weeks before being placed with his adoptive parents. The mother failed to comply with the case plan. He continued to have supervised visits with his birth mother until the adoption was finalized at 2-1/2 years.

I also learned from the report that Tyler was hospitalized when he had the tubes put in his ears at 1 year old, and again, when the circumcision was performed at age 2. This could have constituted a trauma for him.

Contrary to the AM's report at our intake session, the adoption report did not indicate any use of drugs or alcohol by the birth parents. It also did not indicate any physical abuse or domestic violence. It did report that Tyler had a half-brother who had been admitted to the hospital for "failure to thrive, dehydration, and malnutrition." Tyler was 2-1/2 months old at this time.

I faxed a release of information to the [mental health center 2] the next day and requested the ARNP call me. I called Tyler's AM to ask her to contact the pediatrician or pharmacist for information from the medication history that was missing from the neurologist's records and to bring copies of Tyler's report cards to the next appointment.

At the next session, Tyler's AM expressed several concerns:

- Tyler cannot get along with others. She reported she went to give him his money at the bus stop in the morning. She stated, "He's sitting by himself on the ground with his head down. All the other kids at the bus stop are cutting up." She asked him why he wasn't with them, and he replied, "They don't like me."
- He does not defend himself; he is picked on at school. A student threw a pen that hit him in the cheek; the teacher saw, and the student got in trouble.
- She expressed that she and Tyler's AF "are having a hard time liking him." She stated his AF said, "If this is how we are feeling, imagine the people at school." She reports she is not seeing results with the Kapvay. She stated she is "on edge -- the slightest thing gets to me. I've forgotten what it's like to be a mom. I'm

strictly the disciplinarian. I go in his room to give him love and find him doing things he is not supposed to be doing.”

- Tyler’s AM stated his cousins are coming to visit. “They are really good kids -- achievers. They love Tyler and work with his issues.” She is afraid Tyler will embarrass his sister in front of them at the soccer field.
- She worries that video games are his “only outlet,” and he is “learning to exit.” She stated, “It’s just us three.”

In the session with Tyler, he completed the Adolescent Dissociative Experiences Scale (A-DES; Armstrong et al., 1997; Appendix I). A score of 4 or more is considered indicative of pathological dissociation (Putnam, 1997). Tyler’s score was a 3, but he had four notable items that indicated:

- He is able to dissociate.
- He goes away in his mind.
- His ability to do things changes.
- He isn’t sure if he thought of something or really did it.

Tyler was avoidant when I tried to discuss these items in depth. It appeared he felt guilty or shameful that he had what he calls “feelings that shouldn’t be there” such as “anger when I should be happy and jealous of sister.” I noted that I planned to review the records Tyler’s AM brought and to rule out dissociative symptoms.

I attempted to call the psychiatrist who referred my first dissociative client to consult with, and left two messages. I also tried to call the pediatrician’s office twice to ask for help deciphering the handwriting.

In the meantime, I met with Tyler's parents. His AM reported he was "like a zombie" when they went to the museum and a movie yesterday. He thought it was due to medication, however, Tyler told her it was because he didn't "get a good sleep." Tyler's AM reported he is still wetting every night, even when she wakes him up. She reported when she gets him up, he is "getting mad" and he's "not all there." She stated they have not tried a sleep alarm due to the cost. She reported he also has frequent nightmares. He will go back to see the neurologist next month. She reported everything went fine at the soccer field with the cousins.

I reviewed Tyler's treatment and history with his parents and discussed their interactions with him. I explained the impact of trauma on behaviors and the possibility that he is experiencing a somatic dissociation. Basically, the enuresis might be a trauma re-enactment from the night at the hotel. I explained that if there is dissociation, the child cannot get better unless it's addressed (Wieland, 2011); this would require notifying Tyler that he was adopted. Tyler's parents appeared to have an increased awareness of the need to have positive interactions with him. They appeared open to discussing his history with him. I planned to consult with other professionals to confirm my suspicions as I knew it would be difficult for the parents to tell Tyler he was adopted.

I spoke with the assistant at the pediatrician's office the same day. She was able to help clarify some of the notes. However, she explained that they were in the process of transferring over to electronic records, so some of the notes were not available. I was able to combine the neurologist and pediatrician records into a Medical History Summary for Tyler (Appendix L). It provides summary information of exam notes, diagnoses, medications, side effects, behaviors, and recommendations made for each appointment.

External corroboration. Over the next five days, I consulted with the psychiatrist who referred my first dissociative child to me, the ARNP at the neurologist's office, and the ARNP at [mental health center 2]. The psychiatrist stated that it is possible the enuresis is somatic, but difficult to prove scientifically. He stated it was possible to have some dissociative symptoms due to his history. The ARNPs both concurred the enuresis could be somatic. One recommended telling Tyler he was adopted. The other stated he "needs therapy more than anything."

As a final effort, I sent the following email to the ISSTD Child Therapists list serve:

Hello Colleagues,

I am wondering if you could give me some feedback regarding a 12 year old client I have been seeing for almost a year. He has been diagnosed ADHD since he was 6 years old. He has been on just about every ADHD medication there is to no avail. He made all A's his first couple years of school, but he began to go downhill and barely passed 6th grade this year. His mother said he would do his homework, but forget to turn it in. He does very poorly socially at school. The kids find him annoying – as does his younger sister (biological child of parents). I believe he is emotionally bullied at school. He also has enuresis at night with no medical cause. He was adopted at 6-1/2 months. He was left in a car seat in a car while his bio. mother went on "a date" at a hotel at 3 a.m. (Her psych eval indicated she was mildly mentally retarded). When they found him, he was soaked through and through with two bottles of curdled milk next to him. He scored a 12 [13] on the CDC that his mother completed. Father's comments

corroborated mother's. On the ADES, he had 4 notable scores that indicated: he is able to dissociate, he goes away in his mind, his ability to do things changes, and he isn't sure if he thought of something or really did it. He did not score a 4, but I thought those were significant. There is more to it... but even from this, is it too big a jump to think there could be a somatoform dissociation causing the night time enuresis? I spoke with the nurse practitioner at the neurologist's office. She agreed it could be somatic. I spoke with a friend of mine who is a psychiatrist. He said it is possible. Neither of these are "experts" in dissociation. This child has been to two agencies to see a psychiatrist with two very bad experiences in that they did not even bother to obtain his previous records before they saw him (after the mother signed the releases at the initial intake appointments that these agencies require). I know the doctor faxed me the records within 24 hours of faxing him the release, so there is no reason they should not have gotten the information. I have tried to contact both of these agencies, but they have not returned my calls. Do you have any other suggestions of what I should do to rule it out?

The parents have not told this child he is adopted, and although I have spoken to them about telling him, they have consistently told me they do not want to do that. However, if this is in any way a possibility, then they will have to tell him in order for us to work on it. I don't want to put them through this unless I am as sure as I can be.

My impression of this child is that he does not behave the way he does on purpose. He really wants to "be better". He perceives himself to be friendly, but

that others “are not friendly to me”. He has to change his own bedding and do the laundry, so there is a consequence for wetting the bed. Mom even wakes him up once or twice a night to try to prevent it -- doesn't usually help. Mom is not the most consistent parent, but his sister is not having the problems he is; so I would say that she is a “good enough” parent. She and the father seem genuinely concerned for their child.

Thank you for your thoughts!

Dr. Wieland responded, “The connection between early trauma and present symptom is so clear and the indications of dis [dissociation] are clearly there” (personal communication, June 19, 2012).

Na'ama Yehuda stated:

It may not be so strange to consider that at least PART of the presentation at this time is related to unprocessed trauma from his early months. Whether it is a 1:1 with the enuresis or not may be something to find out more about later on (if it is a dissociative response, then it might be something that'll come up from him as you – and him – get to understand more about his trauma and reactions to it and the making of his inside experience). But whether it is directly related to that particular trauma, or representative of a younger state of being (aware or not); or a general issue with feelings of lack of control and overwhelm that may be a somatic emotive memory – they do need – and deserve – to be addressed. (personal communication, June 19, 2012).

Unfortunately, I did not get to address any of his trauma with him. Tyler's AM could not reconcile it within herself to tell him about his adoption. I had given her the

chapter about Ryan (Waters, 2011) to read to help her understand more about somatic dissociation. She could not read the chapter herself: She informed me she gave it to her sister to read. She did not want anything in the house that might lead Tyler to the knowledge that he was adopted, or perhaps to remind herself of that. I offered to let her come to my office while he was in school to read the chapter and any other books on adoption that she would like. I tried to help her to identify her thoughts about telling him that he was adopted, and prepare her and the AF to disclose, but she decided not to. She discontinued counseling soon after.

Within-Case Analysis

As in the analysis of Emily's case, the analysis of the process of diagnosing a dissociative disorder in Tyler's case revealed factors that impeded the recognition of dissociation and factors that advanced the recognition of dissociation. However, the analysis also revealed a change in the diagnosis. This was an unexpected result of the analysis, but it adds to the knowledge obtained from this study. These results will be discussed below. Then a cross analysis of factors common to both cases will be presented.

Factors that impeded the recognition of dissociation.

Therapist factors. Even though I had been studying dissociation, I still *overlooked the assessment* of it in the beginning of this case indicating a need for more *knowledge and training* paired with *practice and experience*. I had the adoption report at the intake, but it did not have any significance until I learned more about trauma and dissociation. My *lack of suspicion* resulted in a *misdiagnosis*. I diagnosed Tyler with ADHD, a *more common diagnosis*. I still *lacked the knowledge* that every child should be

assessed for trauma at the intake regardless of the presenting problem (Nezmer, 1998). I still did not *ask the right questions* about trauma. I still did not have enough *personal experience* to *suspect* dissociation or *differentiate all the symptoms* at the intake.

I also still lacked *self-confidence* in diagnosing dissociative symptoms. Even after I administered the CDC (Putnam et al., 1993) and the A-DES (Armstrong et al., 1997), and the results indicated dissociative symptoms, I made a note that I planned to rule out dissociative symptoms.

Parent factors. Tyler's AM also *lacked knowledge* of trauma. She responded "no" when I asked about the types of trauma on the intake form, i.e., physical, sexual, emotional, or domestic violence. Tyler's AM also *omitted pertinent information at the intake*. She did not inform me that she had had a miscarriage, and it appeared that this was still an unresolved grief for her. Main and Hesse (1990) theorized that the parent's unresolved grief of an attachment figure could result in frightening or frightened behaviors to the child; this would have been information to assess further. She also responded "no" to the question on the intake about previous counseling. Further questioning revealed the answer to this question to be "yes." This indicates the importance of conducting *ongoing assessment, asking the right questions, and gathering information* from all sources. This may also raise the therapist's awareness that caregivers *may not be accurate historians and/or may not be reliable reporters*.

In addition, Tyler's AM had several attributes that may have raised red flags to look for *pathology in the parent*: She had her own memory problems and forgot many appointments. She did not bring the report cards requested by the neurologist or me. She did not follow through with recommendations from the neurologist for counseling and

psychiatric follow-up for Tyler. Nor did she follow my recommendations for an evaluation of her own health. She also displayed a pattern of doctor hopping, i.e., she went back and forth from the neurologist to the pediatrician, and she planned on switching psychiatrists when she became frustrated with one: She went to the pediatrician the week before the appointment with the psychiatrist because they “couldn’t wait any longer.”

A lack of consistency in counseling sessions may also have been a barrier. The more often the therapist gets to see a child, the more they are likely to recognize if there is a switch in the child’s normal behavior, affect, or demeanor. Large gaps between counseling appointments also make it difficult to establish and maintain rapport, and may interfere with the level of trust and disclosure. Frequently missed or forgotten sessions also interrupt the continuity of sessions and make it difficult to stay on track and follow through for the therapist, parent, and child. This was a significant factor in this case.

Other professionals. Tyler’s psychiatrist, neurologist, ARNPs, and pediatrician also exhibited the theme, *a lack of knowledge and training about dissociation leads to a lack of suspicion and misdiagnosis*. They gave the *more common diagnoses* of ADHD. Although I did not encounter skepticism with any other professionals in this case, I did encountered difficulty in trying to *consult with them*. The psychiatrist at [mental health center 1] did not return the call, and it took several attempts to reach other professionals. Another obstacle to proper diagnosis is that the two psychiatrists did not *obtain records* prior to the appointment one month after the initial intake when releases were signed.

Factors that advanced the recognition of dissociation.

Therapist factors. *Increasing knowledge* and *repetition* were significant factors in recognizing dissociation in this case. *Personal experience* and *practice* increased my ability in, and the likelihood of, diagnosing dissociation. I had only worked on the diagnosis of one child at this time. I needed to *practice*, so that I would remember automatically to do a trauma assessment for every child (Nezmer, 1998) at the first session and to be able *differentiate dissociative symptoms* from other symptoms.

Increased knowledge was the catalyst to recognizing Tyler's *trauma history*: He had experienced emotional abuse, neglect, poor attachment, loss of parent by death/separation, illness/medical procedures, and peer rejection. This *knowledge raised my suspicion* that he may be dissociative and led to an *ongoing assessment* of symptoms.

I began to *ask the right questions* of Tyler's AM about his symptoms, such as exploring somatic symptoms, e.g., enuresis, burning sensation. I also had *increased knowledge about screening instruments*; I administered the CDC (Putnam et al., 1993) to Tyler's AM and the A-DES (Armstrong et al., 1997) to Tyler. Tyler revealed in our discussion of the A-DES that he felt guilty, or shameful, for having "feelings that shouldn't be there" such as "anger when I should be happy and jealous of sister." A statement like this may point to a dissociated state.

Reading and hearing information and *seeing it applied to cases* were key factors in learning to recognize dissociation. Ryan's case (Waters, 2011) was helpful because the author gave a description of somataform dissociative symptoms. Dalma, in Baita's (2011) case, was called by two names like Tyler. The similarities in the cases and Tyler's symptoms influenced my differential diagnosis.

Ongoing assessment to rule out a medical cause for symptoms also helped to recognize dissociative symptoms. Tyler had indicated amnesia for a comment he made in a session. Memory loss may be due to seizures, but the neurologist ruled out seizures when he did the follow-up EEG. The urologist ruled out a medical cause for enuresis, which led to the suspicion of a somatic symptom.

Recognizing that *the treatment or the medication is not working* may be another factor that increases the suspicion of dissociation. I tried various approaches to treatment, and Tyler had been on just about every ADHD medication there was for six years, to no avail. So, if the diagnosis was correct, then I questioned whether inconsistent parenting was the problem. Because, his sister did not have the problems he did, I presumed that their parenting, though not perfect, was good enough (James, 1994). This led me to reconsider the diagnosis.

Reviewing the records is also an important factor in expediting the diagnosis. When I did the intake interview, I did not know to assess for other traumas. Tyler's AM had provided information at the intake about the incident when his birth mother took him on a date with her to a motel at 3:00 a.m.: "When the mother was asked when Tyler was last fed, the mother produced two bottles of curdled formula from the car seat that the baby had been in all day. The investigator noted that the diaper and car seat were saturated with urine." This incident did not register in my mind as a *possible trauma* at that time. However, when I *reviewed the chart*, this information jumped out at me. The record also noted he had been examined at the hospital that day for a swollen red spot on his thigh; I imagined this could have been caused from the urine touching his skin. This led me to question the possibility that Tyler's experiences of "burning sensations" were a

somatic memory as the doctor could find no medical basis, and the nightly enuresis may be a trauma reenactment of that night. In other words, “the individual apparently ‘remembers’ what happened through reliving these nonverbal iterations of the historical traumatic event or through mysterious physical symptoms that seem to have no organic basis” (Ogden, Minton, & Pain, 2006, p. 234).

Reviewing the chart periodically is actually a form of *ongoing assessment*. A piece of information by itself may not mean anything, but in the context of several sessions, the therapist may see a pattern or be better able to construe the meaning, i.e., *differentiate the symptoms*:

- I noticed the symptom of *amnesia* in a session when Tyler reported he would “do a business like his dad,” and then the next week said, “I would never do that.”
- I noted that Tyler’s AM, the teachers, and I all expressed the belief that his *behavior was not on purpose*. At first glance, this appears to be a problem of impulse control. However, it may mean that he *does not have control of himself* and, instead, is indicative of a dissociated alter state.
- I noted a repeated theme of *regressive behaviors*, indicated by sleeping in a fetal position, arguing with a six year old, playing Hot Wheels, and his bed time.

Exploring the meaning of statements others make can help to differentiate dissociation from other symptoms. For example, the teachers used phrases like “tuning out”, and Tyler’s AM said he is “learning to exit.” These may or may not be pathological dissociative processes. Reading a book and “tuning things out” is on the normal end of the dissociative continuum. “Learning to exit” may be normal, or not. If he is “going away in his mind,” and it becomes a habit, it could be pathological.

Parent factors. A factor that could have been an earlier indicator to look for dissociation in this case was the *family secret* that Tyler was adopted. It was almost as if Tyler's AM was intentionally dissociating herself from the fact that he was adopted; she could not even read a chapter about it. He was not allowed to know about this, so if he had some inner knowledge of it, he had no choice but to dissociate it from himself.

The *family secret* also may have been a factor in Tyler's AM's report that, "He lies all the time." It appears that he may have been engaging in a parallel process. It is possible that he knows there is a "lie" in the family. He last saw his birth mother when he was 2-1/2 years old. At this age, he has an explicit memory of her (Solomon & Siegel, 2003). However, even as a toddler, he was able to understand that it was not an acceptable topic; therefore, it is a part of him that he must dissociate. *Lying* is also a common symptom of dissociation.

I also noticed a pattern of *inconsistent parental support and perceptions* in Tyler's AM's remarks, e.g., "not doing on purpose; I'm done!; I'm not giving up; we're having a hard time liking him." As I explained previously in Emily's case, these changes in the AM's acceptance and rejection of him may create a disorganized attachment and increase Tyler's vulnerability to dissociate (Liotti, 1999, 2009).

Tyler's AM's video tape of Tyler's comment, "That's not me," was helpful in diagnosing dissociation, although I did not recognize it until I *reviewed the chart*. In the video clip, Tyler does not own the experience: It is an instance of *depersonalization*.

Other professionals. Finally, the *consultation* with other mental health professionals and experts in dissociation provided confirmation of the diagnosis. This

consultation also *increased my confidence* in my ability to recognize symptoms of dissociation.

Expressive therapies. When I *reviewed the chart*, I found two items that may have helped to speed up the diagnosis of a dissociative disorder. I had noted that Tyler's Kinetic Family Drawing (Burns & Kaufman, 1970) did not have faces. I stated that it might be due to several reasons, one of them was "possibly hiding emotions or not aware of them." This observation, in addition to several other similar statements regarding his lack of awareness, led me to recognize symptoms of depersonalization.

The picture of the family's sand tray really was worth a thousand words. It helped to illustrate the unresolved trauma Tyler's mother had from her miscarriage and to exemplify other family dynamics. However, when I considered it in context with the other data in the chart, I became aware of other important aspects of it. For example, Tyler used a lot of fencing, which may indicate a need for protection in a sand tray (Homeyer & Sweeney, 2011). He fenced off two miniatures, a three-headed dog and a dragon. It is possible that these indicated the parts of him that he wants to keep dissociated.

These are merely hypotheses that would need to be discussed with Tyler. Again, expressive therapies can provide additional information, but they are not used by themselves for assessment purposes (Malchiodi, 2005).

An unexpected result. My original work with Tyler resulted in a diagnosis of somatoform dissociation, but I was still doubtful. However, as I wrote this case, I not only became more certain that he had a somatic dissociation, I also began to think that he may have a dissociative disorder that was higher on the continuum. I noticed several

instances of depersonalization and other symptoms that could warrant further assessment with him. (See Appendix I). This may be due to *continued training* that I received from (a) attending another conference, (b) completing the on-line course, (c) continued reading of the literature, and (d) consultation that I have engaged in two times per month in the last six months, as well as my increased *experience* as time has passed, and I have worked with other dissociative children.

I also began to wonder if Tyler's AM might have a history of dissociation due to her forgetfulness. Whatever her memory problems were attributed to, I wondered whether her issues were contributing to Tyler's symptoms. Research has shown there is a familial component to dissociation that may be learned (Yeager & Lewis, 1996). This points to the importance of the *family assessment* in the process and *ongoing assessment* as this information was not available at the first session.

Cross-Case Analysis

A within-case analysis of each case presented individual themes that contributed to the recognition of a dissociative disorder. A cross-case analysis was completed to identify themes that were common to both of the cases.

Factors that impeded the recognition of dissociation.

Therapist factors. The first assumption for this study is that a *lack of knowledge and training* in identifying dissociative disorders results in a *lack of suspicion* (Kluft, 1985a) and leads to a *delayed diagnosis or a misdiagnosis* of dissociative disorders in children. This was, perhaps, the greatest impediment to the diagnostic process in both cases. A lack of knowledge contributed to many missed opportunities for an earlier diagnosis.

First, as in Emily's case, a dissociative disorder could not even be suspected, or considered, without the knowledge that dissociative disorders existed in children. The *lack of suspicion* of dissociation means they will not be considered in the differential diagnosis of symptoms, resulting in symptoms being attributed to more common diagnoses. Furthermore, even though I knew about the existence of dissociative disorders in children when I began working with Tyler, I still missed considering it. I still *lacked the knowledge of and experience* in the assessment process.

I *lacked the knowledge* for a comprehensive *trauma assessment* for both Emily and Tyler. I did not know that every child should be assessed for trauma and dissociation at the intake session, no matter what the presenting problem is (Nezmer, 1998). I also did not know the various forms of trauma associated with dissociative disorders.

Both cases also reflected a *lack of knowledge in differentiating symptoms* of dissociation. Descriptions of inattentiveness, impulsivity, doesn't listen, can't stay in seat, and so forth, were *misdiagnosed* as symptoms of ADHD. For example, knowledge of dissociation assisted in recognizing that inattentiveness may actually be a trance state. Children may "tune out" when they want to avoid trauma reminders or escape anxiety (Waters, 2012). When Emily was shown the picture of her birth parents, I thought the blank look she gave meant she did not recognize them. It is more likely that the picture triggered a memory and/or anxiety. For both Emily and Tyler, impulsivity may not have been due to a lack of control, but rather attributed to the other-control of an alter state. Lying behaviors could be identified as amnesia for behaviors or depersonalization. Emily took too many cookies. When her AM confronted her, she denied it. When her AM

persisted, she said, “O.k. fine. I did it, but it wasn’t me.” Tyler stated about the video clip of himself, “that’s not me.”

Another way in which a *lack of knowledge* was an obstacle to diagnosis was in not *asking the right questions*. Neither of the parents in these cases knew about the various types of trauma. I did not ask the right questions to gather this information. I also did not *ask the right questions* about the symptoms. For example, it would not be helpful to ask, “does your child have derealization?” The parent or child likely does not know what that means. Rather, asking the child a question like “Do you ever feel like you are not really there, like you are watching yourself from a distance?” (Silberg, 2013, p. 38) elicits information about the child’s experience of a symptom.

Another factor that impacted the diagnosis of a dissociative disorder in both cases was *missing information*. Some of the information was not available in the beginning such as Emily’s birth records. Other information needed to be obtained from other sources, e.g., doctors, school information. Requesting all records in the beginning may speed up the process.

A final factor that impacted the time it took to make a conclusive diagnosis was the therapist’s level of self-confidence. Self-confidence increases with *knowledge and experience*. Consulting with other professionals was used in both cases and is an important professional and ethical consideration when working in a new area.

Parent factors. The two cases studied both involved adoptive parents. The AMs *indicated a lack of knowledge* of trauma at the intake session. Neither reported any trauma. This indicates the need to *educate* parents about trauma and dissociation and to *ask the right questions*.

Another common theme in both cases was the *omittance of information at the intake* session by both parents. Emily's AM did not provide information about her two week hospitalization for malnutrition when they got her. This was not a therapist error as a question about hospitalizations was asked on the intake form. Tyler's AM responded "no" to a question about previous counseling when, in fact, the answer was "yes." This indicates that caregivers may not be accurate historians and/or may not be reliable reporters. It emphasizes the need for *ongoing assessment, asking the right questions, and gathering information from multiple sources.*

A lack of consistency in counseling sessions was noted for both cases. I did not see Emily for three months due to a focus on sessions with her parents for two months and a one month gap. When Emily returned she asked where I had been. Gaps in counseling for Tyler often made it difficult to stay on track with the plan for the next session, and homework was often not completed. Regular sessions may increase the likelihood that the therapist will notice changes in the child that may indicate dissociation.

Other professionals. The other mental health and medical professionals involved with Emily and Tyler all shared a *lack of knowledge and training* in dissociation. In both cases, the professionals gave more *common diagnoses*. Consultation with other professionals was also an obstacle in both cases.

Factors that advanced the recognition of dissociation.

Therapist factors. Several themes pertaining to the therapist that may expedite the diagnosis were present in both cases. *An increase in knowledge and personal experience* increased my ability to *ask the right questions, assess for trauma, and differentiate*

dissociative symptoms. Reading and hearing information repeatedly and seeing it applied to cases helped to increase my recognition of dissociation. The use of assessment instruments such as the CDC (Putnam et al., 1993) and A-DES (Armstrong et al., 1997) increased the recognition of dissociative symptoms. Reviewing the chart and ongoing assessment alerted me to the recognition that the medication and treatment were not working. Reviewing the chart was also helpful in observing repeated behaviors.

When I reviewed the charts with the knowledge and experience I have now, I realized I would have begun a further assessment for dissociative symptoms and/or disorders at the very first session. In Emily's case, dissociation was never considered in her first period of counseling which lasted one year. Consideration of dissociation began after four months in the second period. However, due to a lack of confidence, it took one year to reach a conclusive diagnosis. Once I began to suspect dissociation in Tyler's case, the diagnostic conclusion was reached in just over four months.

Another theme the two cases had in common was that a review of the charts was initiated after realizing the medications and the treatment were not being effective. Ongoing assessment is an important part of all counseling sessions.

Parent factors. Both AMs indicated a theme of inconsistent parental support and perceptions. Their fluctuations in acceptance and rejection of their child may lead to, or maintain, a disorganized attachment pattern (Liotti 1999, 2009) and contribute to dissociative behaviors. Recognition of this pattern may increase the suspicion of the therapist to assess for dissociation.

Both AM's brought in a video clip of their child's behavior that assisted in the recognition of dissociation. The video of Emily's behavior clearly demonstrated her

regression through her language, e.g., “nop it!” instead of “stop it!,” as well as other dissociative behaviors. Tyler displayed dissociation when he saw himself on the video and remarked, “That’s not me.”

Other professionals. *Consultation* with other professionals in both cases helped the therapist to increase *confidence* in the diagnosis of a dissociative disorder. Consultation is important in mentoring therapists with little or no experience in dissociative disorders and a requirement for ethical practice in new areas.

Expressive therapies. Both cases employed the use of expressive therapies. Emily’s play themes and Tyler’s drawing and family sand tray provided support for the existence of dissociative symptoms.

Summary

This chapter presented the results of the analysis of archival data for two cases. With-in and cross-case analysis identified several themes that may help in the recognition of dissociative disorders in children. The findings will be discussed in Chapter Five.

Chapter Five – Summary and Conclusions

Chapter Four presented an in depth description and analysis of two case studies using archival data from multiple sources. Several themes were identified using a within-case and cross-case analysis. The identified themes will be reviewed in this chapter within the context of the present literature along with the limitations of the study, and recommendations for present use as well as future research.

Statement of the Problem

Research on the diagnosis of dissociative disorders in children is sparse. The literature indicates that the majority of DID cases are misdiagnosed for years (Coons, 1984) and often are not diagnosed until adulthood (Peterson, 1990). Because the majority of adults report DID began in childhood (Bliss, 1980; Putnam et al., 1986; Putnam, 1997), diagnosis and effective treatment at an earlier age may diminish years of pain and suffering for children and adults.

Methodology

This research used a qualitative collective case study design to explore the process of diagnosing dissociative symptoms and disorders in children. The collective case studies were analyzed using a within-case analysis of themes in each individual case and a cross-case analysis to describe themes common to both cases (Creswell, 1998). This study analyzed cases from the beginning of treatment to discover how the diagnosis was recognized and what common themes may exist to expedite the diagnosis. A chronicle of the therapist's training and development is a concurrent focus. The process is described in

detail to assist counselors inexperienced in dissociative disorders to make a more expedient diagnosis in order to allay the years of pain and suffering experienced.

Findings

The purpose of this study was to explore the process of diagnosing dissociative disorders in children in order to determine how they can be recognized earlier and what common themes may help to expedite the diagnosis. It was assumed that a lack of training would be a primary factor resulting in a lack of suspicion (Kluft, 1985a) that would then lead to a delayed diagnosis or misdiagnosis. The diagnosis of a dissociative disorder would be overlooked in the differential diagnosis due to symptoms similar to other, more common diagnoses. It was also assumed that the identification of common themes could lead to an earlier diagnosis. These assumptions were substantiated in the analysis of both cases and will be discussed further.

Themes were identified in two categories: factors that impeded the recognition of dissociation and factors that advanced the recognition of dissociation. Although the first category appears to be antithetical to the goal of expediting diagnosis, obstacles must be identified before they can be removed. Themes were identified in reference to the therapist, the parents, and other professionals.

Factors that impeded the recognition of dissociation. A lack of *knowledge and training* was the primary factor that hindered the recognition of dissociative disorders. Kluft (1985a) identified a lack of suspicion on the part of clinicians. He stated they were skeptical about the diagnosis or unfamiliar with it. This proved to be true in this study. I had no knowledge of dissociation in children before I received my first referral. It was not until I began working with another child that I noticed similar symptoms in Emily.

Yet I remained skeptical about it. I also encountered skepticism on the part of Emily's psychiatrist and other clinicians presenting at a conference. As a result of this lack of knowledge and consideration of the symptoms, Emily and Tyler were both *misdiagnosed* with a more *common diagnosis* by all the professionals involved including pediatricians, neurologists, ARNPs, and psychiatrists.

A lack of knowledge resulted in errors in other areas. I did not have knowledge of the trauma factors associated with dissociation, or the training to know to assess for trauma at the first visit. Trauma is an antecedent to many cases of dissociative disorders and raises a red flag. As noted in the literature review, some cases do not indicate a traumatic experience (Coons, 1996; Malenbaum & Russell, 1987). However, this does not mean with any certainty that there has not been one. The very act of removing a child from their biological parent constitutes a loss of an attachment figure, and may be traumatic to some children (ISSD, 2004; Wieland, 2011). Neglect is another factor that may be considered a trauma to young children (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997).

Even though both Emily and Tyler were removed from their biological parents due to neglect and suspected abuse, I did not define their experiences as traumatic until I received further training. Likewise, neither adoptive parent understood the definition of a trauma, and did not report a trauma occurring. As time passed, it would come to light that both of these children experienced multiple traumas.

Another therapist error occurred during the initial assessment. Both AMs completed Symptoms Checklists. A differential diagnosis could not take place without knowledge about dissociative symptoms. If it had, then Emily and Tyler may not have

been misdiagnosed, or at least red flags would have been raised. More details about their symptoms can be found in the Assessment Charts in Appendices H and I.

Findings also indicated that not all information was obtained at the initial intake. The AMs omitted some information signifying that they may be poor historians or unreliable reporters. The therapist should make it a point to request all information when possible, e.g., medical records, school records, etc. Some information was not available, e.g., Emily's birth records.

Another factor that delayed the diagnostic process was a lack of personal experience. This contributed to a *lack of confidence* in my diagnosis and a *reliance on a more experienced mental health professional's diagnosis*. This corroborates the themes reported by Ronnestad and Skovholt (2003) related to counselor development. Although the trend is to shift from a reliance on external expertise to an internal focus, they state that new challenges may cause "recycling loops in which themes such as lack of confidence in one's ability may emerge repeatedly." Melchert, Hays, Wiljanen, and Kolocek (1996) state that Bandura's self-efficacy theory (1977) supposes that a counselor's self-confidence increases as they acquire training and experience.

Additionally, a lack of consistency in counseling sessions occurred with both families. Consistent sessions may increase the ability of the counselor to recognize changes in the child. It also makes it easier to maintain rapport and track progress.

Data analysis indicated other barriers to diagnosis may include pathology in the parent and the existence of family secrets. Other professionals also presented an obstacle in that they often times did not return calls, or waited an extended time to do so.

Factors that advanced the recognition of dissociation. Counteracting the lack of knowledge would be to increase the knowledge of trauma and dissociation through increased trainings. Repetition and practice play an important role in learning. Reading descriptions in the literature, attending trainings, conferences, and on-line courses are ways to increase knowledge.

Increased knowledge leads to a thorough trauma assessment, symptom differentiation, and the use of screening assessments. It increases the clinician's ability to ask the right questions.

Two related factors that may contribute to earlier diagnosis include reviewing records and ongoing assessment. The therapist is able to see repeated patterns and behaviors over time that may help with differential diagnosis. In both cases the finding that the medication and treatment were not effective raised suspicions to assess further.

Consultation with other therapists may help to recognize and confirm the diagnosis. Hornstein (1998) advocates meeting with all other professionals involved. Consultation is helpful for clinicians new to dissociative diagnoses, and may increase their self-confidence.

Assessment of parental attachment patterns may raise flags for possible dissociation. This study found that both AMs had inconsistent parental support and perceptions about their child. Attachment is a key component of several theories reviewed in Chapter Two: The Discrete Behavioral States Theory (Putnam et al., 1993), Disorganized Attachment (Liotti, 1999, 2009), and Structural Theory of Dissociation, (Steele, 2005).

A final factor that may advance the diagnosis of a dissociative disorder is the use of expressive therapies. Emily appeared to express symptoms of dissociation through her play, while Tyler may have shown some signs of dissociation in his Kinetic Family Drawing (Kaufman, 1978). Tyler's family's sand tray was very revealing of family dynamics and possible dissociation. Expressive therapies use both verbal and nonverbal expression (Malchiodi, 2005), and interpretation based on one piece is not advised.

Limitations of the Study

The Institutional Review Board requirements for research with minors are more stringent than those for adults. The stipulation that I had to have a signed release to use the archival data reduced the number of cases for this study to two. This limits the amount of comparisons for similarities and differences that can be made among the cases and between the different types of dissociative disorders. It is interesting that the two cases cover different gender and age levels at the beginning of treatment. However, both are Caucasian, and it is possible that different ethnicities may present dissociative symptoms differently.

The children studied in these two cases are both adopted. Adoptive parents may have limited information about the child's history. Adoptive parents may also respond differently to dissociative symptoms than biological parents or grandparents.

Qualitative studies are not undertaken in order to generalize to the larger population. Thick, rich description is used to facilitate the reader's conclusion as to whether transferability is possible based on shared attributes. The information in this study may not be transferable in other situations.

Another limitation of this study was the use of archival data. This prevented me from being able to speak to the parents or children to clarify information or to gather any new or updated information. It also prevented me from using member checking as a form of establishing trustworthiness.

My personal interpretations of the data may also be a limitation. Although I could not use information from the other two cases, it is still information that I have, and it may influence me. I have used an auditor as one way to minimize bias.

Recommendations for the Use of Present Findings

- The findings from this study may be useful in training students or clinicians with little or no experience to recognize dissociative symptoms and disorders in children. The in depth descriptions may increase the understanding of the presentation of dissociative symptoms.
- The Assessment Chart may be used as a template to ensure a comprehensive assessment and to track continued ongoing assessment.
- The findings from this study may be used to educate other mental health professionals and increase the awareness of dissociative disorders in children.
- The findings indicate the need for consultation and mentoring by experienced clinicians.
- The findings of this study emphasize the need for collaboration among all professionals involved in the treatment of a child.
- The findings from this study highlight the need to educate parents about trauma and dissociation and to ask the right questions.

Recommendations for Future Research

The current study provides rich description of the process involved in the diagnosis of dissociative disorders in two children. Future research may focus on a larger study with multiple therapists and sites. It may also be helpful to research differences between new and experienced therapists recognition of dissociative disorders using case studies.

Because there is not any consensus on the criteria for dissociative disorders (Silberg, 2009), future research should focus on measureable definitions of symptoms or other criteria.

Research is also needed regarding the efficacious treatment of dissociative disorders in children. Future research may also include more expressive artwork or play therapy.

Conclusions

Research pertaining to the diagnosis of dissociative disorders in children is scarce. The analysis of two cases resulted in the identification of several themes that may expedite the diagnosis of dissociative disorders in children: (a) increase in knowledge of dissociation, (b) personal experience, and (c) consultation. Many of the findings add support to the existing literature.

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Appendices

Appendix A – Parental Permission to Participate in Research Involving Minimal Risk



Parental Permission to Participate in Research Involving Minimal Risk
Information for parents to consider before allowing their child's records to be analyzed for research purposes

IRB Study # 9724

The following information is being presented to help you decide whether or not you wish to allow us to use your child's therapy records in a research study. Please read this information carefully. If you have any questions or if you do not understand the information, we encourage you to ask the researcher.

We are asking you to allow us to use your child's therapy records to take part in a research study called:

A Collective Case Study of the Diagnosis of Dissociative Disorders in Children

The person who is in charge of this research study is Jacqueline J. Reycraft. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by Herbert A. Exum, Ph.D.

The research will be conducted at A New Day Counseling and Development Center, PL.

Why is this research being done?

The purpose of this study is to help clinicians recognize dissociative symptoms/disorders earlier in treatment.

Why is your child being asked to take part?

We are asking to use your child's therapy records in this research study because he/she has displayed dissociative symptoms during treatment and/or has been diagnosed with a dissociative disorder.

Study Procedures

This informed consent form tells you about the procedures for this research study. This form explains:

- Why this study is being done.
- What will happen during this study.
- Any potential benefits of the study.
- Any risks in this study.

Before you decide:

- Read this form.
- Have a friend or family member read it.
- Talk about this study with the person in charge of the study or the person explaining the study. You can have someone with you when you talk about the study.
- Talk it over with someone you trust.
- Find out what the study is about.
- You may have questions this form does not answer. You do not have to guess at things you don't understand. If you have questions, ask the person in charge of the study or study staff as you go along. Ask them to explain things in a way you can understand.
- Take your time to think about it.

The decision to provide permission to allow us to use your child's therapy records in the research study is up to you. If you choose to let your child's therapy records be used in the study, then you should sign this form. If you do not want your child's therapy records to be used in this study, you should not sign the form.

What will happen during this study?

You are being asked permission to use your child's therapy records for this study. The researcher will review your child's records to identify information, e.g., history of trauma, family dynamics, symptoms, behaviors, etc. that may contribute to the diagnosis of a dissociative disorder. If you signed a release to record therapy sessions during treatment, these sessions will be transcribed, and included in the analysis.

Your child's therapy records will be analyzed for themes and patterns individually and then compared with up to three other children's therapy records for commonalities. No identifying information about your child or your family will be included in this study. This means that all names will be changed; no dates of birth or dates of treatment will be used; no medical account numbers, addresses, social security numbers, etc. will be used.

What other choices do you have if you decide not to let your child's therapy records be used?

If you decide not to let us use your child's records in this study, that is okay.

Will your child be compensated for taking part in this study?

You will receive no payment or other compensation for taking part in this study.

What will it cost you to let your child take part in this study?

It will not cost you anything to let your child's records be used in this study.

There will be no additional costs to you as a result of your child's records being used in this study.

What are the potential benefits of this study?

We do not know if your child will gain any benefits from this study.

We do not know if this study will help children with dissociation; that is why we are doing this study. By letting us use your child's therapy records, you are helping us to learn more about dissociation. What we learn may help others in the future.

What are the risks of using my child's therapy records in this study?

Although all direct identifiers such as names, addresses, schools, birth dates, dates of service, etc. will not be used in describing the case studies, there is a minimal risk that someone reading the case study may recognize your child's identity. This is a very small risk, but it is something you should be aware of in making your decision.

Privacy and Confidentiality

We will keep your child's study records private and confidential. The identity of the records used will be known only to the principal investigator. The information will be kept locked in a file cabinet in a locked room at A New Day Counseling and Development Center, PL separate from other records.

Certain people may need to see your child's study records. By law, anyone who looks at your child's records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator, study coordinator, and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and

Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your child's name. We will not publish anything that would let people know who your child is.

What happens if you decide not to let your child's therapy records to be used in this study?

You should only let your child's therapy records to be used in this study if you want to. You should not feel that there is any pressure to grant permission to use your child's therapy records in the study to please the study investigator or the research staff.

If you decide not to allow the use of your child's therapy records:

- Your child will not be in trouble or lose any rights he/she would normally have.
- Your child will still get the same services he/she would normally have.
- Your child can still get their regular therapy services from your regular therapist.

You can decide after signing this informed consent form that you no longer want your child's therapy records to be used in this study. We will keep you informed of any new developments which might affect your willingness to allow us to continue to use your child's therapy records in the study. However, you can decide you want us to stop using your child's therapy records in the study for any reason at any time. If you decide you want us to stop using your child's therapy records in the study, tell the study staff as soon as you can.

- If you decide to stop, your child can continue receiving his/her regular therapy from your regular therapist.

You can get the answers to your questions, concerns, or complaints.

If you have any questions, concerns or complaints about this study, call Jacqueline J. Reycraft at (863)510-5902.

If you have questions about your child's rights, general questions, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638.

If you have questions about your rights as a person taking part in this research study you may contact the Florida Department of Health Institutional Review Board (DOH IRB) at (866) 433-2775 (toll free in Florida) or 850-245-4585.

Consent for My Child's Therapy Records to be Used in this Research Study

It is up to you to decide whether you want your child's therapy records to be used in this study. If you want your child's therapy records to be used, please read the statements below and sign the form if the statements are true.

I freely give my consent to allow my child's therapy records to be used in this study.

I understand that by signing this form I am agreeing to let my child's therapy records to be a part of this research. I have received a copy of this form to take with me.

Signature of Parent of Child Taking Part in Study

Date

Printed Name of Parent of Child Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the parent of the child whose therapy records are being used in the study what he or she can expect. I hereby certify that when this person signs this form, to the best of my knowledge, he/ she understands:

- What the study is about;
- What procedures will be used;
- What the potential benefits might be; and
- What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. The parent signing this form does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. The parent signing this form is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained and, therefore, can be considered competent to give permission to allow their child to participate in this research study.

Signature of Person Obtaining Informed Consent

Date

Printed Name of Person Obtaining Informed Consent

Appendix B – Auditor Information

Work Address: Mark D. Helm, M.D., P.L.
107 Morningside Drive
Lakeland, FL 33803

Phone: 863-683-2600
Fax: 863-683-2604

License: State of Florida: ME0044208

Certification: American Board of Psychiatry & Neurology in General Psychiatry
Certificate #28907, January 1987
American Board of Psychiatry & Neurology in Child/Adolescent
Psychiatry Certificate #2305, September 1988
Fellow – American Psychiatric Association – 2012

Private Practice: Child, Adolescent, & Adult Psychiatry
12/06-present Lakeland, Florida
Child and Adolescent Psychiatry
7/86-8/95 Lakeland, Florida

Hospital Affiliation: Lakeland Regional Medical Center (1986-87; 10/93-12/06)
Medical Director Mental Health Addictions Recovery
(08/95-06/05)
Co-Leader Mental Health Addictions Recovery
(8/95-10/04)
Medical Director Adolescent Inpatient Services
(11/93-12/06)

Palmview Hospital, Lakeland, FL (1986-1995)
Clinical Director Adolescent Psychiatry
(1986-87 & 1988-89)
Clinical Consultant Adolescent Partial Hospital (2/92-8/93)
President Medical Staff (1991-92)

University of South Florida Psychiatry Center (1987-88)

Academic Appointments:

University of South Florida College of Medicine
Visiting Assistant Professor (1986-1993)

Education:

Child Psychiatry Fellowship
Univ. of South Florida College of Medicine (7/84-6/86)
Chief Child Fellow (1985-86)

General Psychiatry Residency Training

Medical University of South Carolina, Charleston
(7/81-6/83) – post graduate training years 1 & 2
University of South Florida College of Medicine
(7/83-6/85) – post graduate training years 3 & 4

Medical School

Saint Louis University School of Medicine
M.S. Degree 5/81

Postgraduate Education

University of Missouri, Columbia
M.A. Biological Sciences 1977

Undergraduate Education

Northwestern University, Evanston, Illinois
B.A. Biological Sciences 1975

Continuing Medical Education in Medical Management

American College of Physician Executives “Physicians in
Management” Seminars I, II, and III (over 90 hours of
instruction in various areas of medical management)

Awards: Hibbs-Biourkard Award for the Outstanding Resident in Psychiatry – 1986 –
presented by the University of South Florida College of Medicine and the
Tampa Psychiatric Society

Publications:

“Impact of a Disaster on a Burn Unit” Psychosomatics, Powers, et. al., 1988
Laboratory Manual for Introductory Zoology Minneapolis, MN; Burgess
Publishing (1977)

Associations:

American Psychiatric Association (1982-present)
Florida Psychiatric Society (1985-present)
Chairman Young Psychiatrists Committee (1988-90)
Chairman Childhood & Adolescent Committee (1992-93)
Florida Medical Association (1986-2000)

Polk County Medical Association (1986-2000)
American Academy of Child & Adolescent Psychiatry (1987-present)
American College of Physician Executives (12/98-2006)
Polk County Public Schools – consulting psychiatrist (1988-7/95)
Florida Baptist Children’s Home – consulting psychiatrist (1991-8/95)
Florida Diagnostic and Learning Resources System – consulting psychiatrist
(1988-7/96)
Plant City DEES Center (for severely emotionally disturbed students) (1986-90)
Youth and Family Alternatives – consulting psychiatrist (8/93-8/95)
Florida Institute for Neurologic Rehabilitation – consulting psychiatrist
(8/93-11/94)
Catholic Charities of Central Florida – Advisory Board Member
(June, 2008-2010)
The Vanguard School – Lake Wales, FL – consulting psychiatrist
(9/2007-present)

Appendix C - Letter of Attestation

June 14, 2013

To Whom It May Concern:

I was asked to perform an audit of the research study conducted by Jacqueline Reycraft, a doctoral candidate at the University of South Florida, Department of Psychological and Social Foundations, Counselor Education program. Ms. Reycraft's research focused on the recognition of dissociative disorders in children.

In order to establish the dependability, confirmability, and credibility of this study, I was asked to complete the following tasks:

- Review the proposal for this study in order to familiarize myself with the research issues and methodology.
- Examine the process taken in analyzing the data, i.e., the audit trail. I reviewed all case documents, methods of data reduction, and coding procedures to ensure dependability.
- Examine the final product in order to confirm that the findings, interpretations, and conclusions are based on the data.
- Provide peer debriefing on a regular basis in order to provide a check on the research process, minimize researcher bias, and ensure credibility.

Using the questions suggested by Miles and Huberman (1994) as a guide, I confirm that Ms. Reycraft has followed a logical procedure in her analysis, all data was considered, including negative data, and researcher bias was taken into account. I hereby attest to the confirmability, dependability, and credibility of this research study.

Sincerely,

Mark Helm, M.D.
107 Morningside Drive
Lakeland, Florida 33803

Appendix D – Symptoms Checklist

Symptoms Checklist – Child & Adolescent

Client Name: _____ Date: _____
 DOB: _____ Age: _____

Please check each symptom below that the child has had recently and which has caused a problem in his/her functioning at home, at school, legally, or with others. Underline any symptoms the child has had in the past.

- | | |
|--|--|
| <input type="checkbox"/> careless | <input type="checkbox"/> blames others for own faults/wrongdoing |
| <input type="checkbox"/> can't pay attention | <input type="checkbox"/> easily annoyed |
| <input type="checkbox"/> doesn't listen | <input type="checkbox"/> angry/resentful |
| <input type="checkbox"/> doesn't finish things | <input type="checkbox"/> spiteful |
| <input type="checkbox"/> disorganized | <input type="checkbox"/> runs away |
| <input type="checkbox"/> often loses things | <input type="checkbox"/> has few friends |
| <input type="checkbox"/> easily distracted | <input type="checkbox"/> withdraws from friends/family |
| <input type="checkbox"/> often forgetful | <input type="checkbox"/> feels ugly |
| <input type="checkbox"/> restless, fidgety | <input type="checkbox"/> feels worthless |
| <input type="checkbox"/> can't stay in seat | <input type="checkbox"/> feels guilty |
| <input type="checkbox"/> can't play quietly | <input type="checkbox"/> loss of energy/tired |
| <input type="checkbox"/> talks too much | <input type="checkbox"/> sleeps too much |
| <input type="checkbox"/> answers before question is finished | <input type="checkbox"/> unable to sleep well |
| <input type="checkbox"/> doesn't wait turn in conversation or games | <input type="checkbox"/> sleepwalking |
| <input type="checkbox"/> acts without thinking | <input type="checkbox"/> suicide thought or attempt |
| <input type="checkbox"/> poor school performance | |
| <input type="checkbox"/> bullies | <input type="checkbox"/> preoccupied with thoughts |
| <input type="checkbox"/> starts fights | <input type="checkbox"/> fearful/afraid |
| <input type="checkbox"/> has used things as weapons | <input type="checkbox"/> feels panic |
| <input type="checkbox"/> cruel to people | <input type="checkbox"/> clinging |
| <input type="checkbox"/> cruel to animals | <input type="checkbox"/> afraid to leave parent |
| <input type="checkbox"/> has stolen things in plain view | <input type="checkbox"/> afraid to go to school |
| <input type="checkbox"/> forced sex on others | <input type="checkbox"/> shy |
| <input type="checkbox"/> firesetting | <input type="checkbox"/> very "controlling" |
| <input type="checkbox"/> destroys property | <input type="checkbox"/> upset by frequent changes |
| <input type="checkbox"/> has broken into someone else's house/building/car | <input type="checkbox"/> pulls own hair |
| <input type="checkbox"/> "cons" others | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> has stolen on the sly | <input type="checkbox"/> clumsy, accident prone |
| <input type="checkbox"/> disobeys curfew | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> has run away overnight | <input type="checkbox"/> soils pants/wets pants |
| <input type="checkbox"/> skips school | |
| <input type="checkbox"/> lies when caught red-handed | <input type="checkbox"/> inappropriate sexual behavior |
| <input type="checkbox"/> has thoughts/plans for harming/killing someone | <input type="checkbox"/> frequent masturbation |
| <input type="checkbox"/> gets physically violent | <input type="checkbox"/> sexually abused |
| <input type="checkbox"/> used drugs | <input type="checkbox"/> physically abused |
| <input type="checkbox"/> smokes cigarettes | <input type="checkbox"/> emotionally abused |
| <input type="checkbox"/> drinks alcohol | |
| <input type="checkbox"/> often loses temper | <input type="checkbox"/> sees things that aren't there |
| <input type="checkbox"/> often argues with adults | <input type="checkbox"/> hears things that aren't there |
| <input type="checkbox"/> disobeys rules | |
| <input type="checkbox"/> deliberately annoying | <input type="checkbox"/> head injury |
| | <input type="checkbox"/> seizures |

demanding
 tantrums
 poor concentration
 daydreams a lot
 complains of frequent aches & pains
(headache, stomachache, etc.)
 change in appetite
 weight loss or gain

feels helpless
 sick a lot
 mood swings
 irritable

Appendix E – Child/Adolescent Intake

CHILD/ADOLESCENT INTAKE

Client's Name _____ DOB _____ Age _____

Ethnicity: _____ Date: _____ Referred by: _____

1. PRESENT SITUATION:

A. Describe the situation/symptoms for which you are seeking help

and what you would like to accomplish: _____

B. How serious is the problem? (Check one)

- Does not affect satisfaction/ability to cope with life.
- Briefly interrupts satisfaction/ability to cope with life.
- Causes mild difficulty enjoying/coping with life.
- Causes moderate difficulty enjoying/coping with life.
- Causes serious difficulty with many areas of life.
- Very serious problem affecting all areas of life.

2. SOCIAL HISTORY

A. Family composition: List the name, relationship, and age of everyone living in the home.

Name	Relationship	DOB/Age

Other Siblings/Significant Family not living in the home:

--	--	--

Has the child/adolescent ever lived with anyone else? If yes, please explain:

B. Child's Parents:

Mother's name: _____

Highest level of education: _____ **Occupation:** _____

Age when first married? _____ **Number of marriages?** _____ **Length of marriage(s):** _____

Present status (Circle one): **Single** **Married** **Divorced** **Widowed** **Deceased**

Father's name: _____

Highest level of education: _____ **Occupation:** _____

Age when first married? _____ **Number of marriages?** _____ **Length of marriage(s):** _____

Present status (Circle one): **Single** **Married** **Divorced** **Widowed** **Deceased**

C. Developmental History: Did the child/adolescent reach the following milestones at a typical age? If no, please explain.

Held head up	Yes	No	_____
Crawled	Yes	No	_____
Sat without support	Yes	No	_____
Walked alone	Yes	No	_____
Said 4 – 10 words spontaneously	Yes	No	_____
Used sentences to express self	Yes	No	_____
Bowel/bladder trained	Yes	No	_____
Rode bicycle without training wheels	Yes	No	_____
Fed self	Yes	No	_____

Colored within the lines	Yes	No	_____
Began to menstruate (if applicable)	Yes	No	_____
Sexually active	Yes	No	_____

D. Prenatal/Postnatal History

Did the birth mother receive medical care during pregnancy? If no, please explain _____ _____	Yes	No
Was the pregnancy full term? If not, what was the length of the pregnancy? _____	Yes	No
Were there any complications during the pregnancy? If yes, please describe. _____ _____	Yes	No
Did the birth mother smoke, drink, or use drugs during the pregnancy? If yes, please describe type, amount and frequency of substance. _____ _____	Yes	No
Did the biological father use drugs or alcohol before conception? If yes, please describe. _____ _____	Yes	No
Did the birth mother take medications during pregnancy. If yes, please describe. _____ _____	Yes	No
Was the birth mother exposed to x-rays during pregnancy?	Yes	No
Was the birth mother under emotional stress during pregnancy? If yes, please explain. _____ _____	Yes	No
Any complications during labor and delivery? If yes, please explain. _____ _____	Yes	No
Was there any lack of oxygen at birth? If yes, please explain. _____ _____	Yes	No

Were forceps used? Yes No

Birth weight: _____ Type of labor: spontaneous induced (circle one)

3. FAMILY HISTORY

Have you or any family members (siblings, parents, grandparents, aunts, uncles, etc.) ever had any of the following? If yes, please explain.

Current or past use of Alcohol/drugs? _____

Legal Involvement? _____

Suicidal behavior? _____

Mental Illness? _____

History of Physical or Sexual Abuse or Domestic Violence? _____

Other pertinent history: _____

4. HEALTH AND MEDICAL HISTORY

Primary Care Physician: _____

Has the child/adolescent had any surgeries, hospitalizations, major accidents, or major illnesses? If yes, describe: _____

List any current medications the child/adolescent is taking:

Medication	Dose	Prescribed by:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any past medications: _____

Describe your child/adolescent's sleep routine. _____

Appetite: Poor ____ Normal ____ Other _____

Any other medical concerns? _____

Has your child received counseling in the past? _____ **If yes, please list the counselor(s) and reason for being seen.** _____

5. VIOLENCE AND TRAUMA

If your child has experienced emotional, physical, or sexual abuse, or has witnessed domestic violence in your home or the home of others, please describe. If more space is needed, please use the back of this page. _____

Does the child/adolescent or other family members have any involvement with DCF or other agencies? Please explain. _____

6. DISCIPLINE

Who disciplines the child? _____

What type of discipline is used? Please describe: _____

Is it effective? _____ **Do parents/guardians agree on discipline?** _____

7. SCHOOL HISTORY

Current school: _____ **Grade:** _____

Did your child attend pre-school? _____ **Where:** _____

Does your child have a learning disability? _____

Has your child attended a special education program/have an IEP? _____

**Has your child repeated, skipped, or had any interruptions to his/her education?
If so, please describe:** _____

Does your child have behavior problems at school? _____

Are you happy with your child's school performance? _____

How many days has he/she missed this school year? _____

How many schools has your child attended in the last two years? _____

Does your child get along well with others? _____

Notes: _____

8. ACTIVITIES AND INTERESTS

a. What activities does your child do in his/her spare time? _____

b. What does your child do well? What are his/her strengths? _____

**c. How many hours a day does your child watch t.v.? _____ ; play video games?
_____ ; use the computer? _____**

9. SPIRITUAL BACKGROUND

Please describe your child's religious involvement, if any. Are there any special religious, cultural, or ethnic considerations I should be aware of as I meet with him/her? _____

10. SUPPORT SYSTEM

When your child needs to talk, who does he usually go to? _____

Appendix F - Emily Treatment Summary

Note: Emily came for counseling at two separate intervals with a three years, one month gap in between. To distinguish the two intervals, sessions from the first period are denoted with a “1” before the session number, and sessions from the second period are denoted with a “2” before the session number.

Session/ Time Between Sessions	<input type="checkbox"/> Child/Family/Therapist Information AF = Adoptive Father FM = Foster Mother SP = School Psychologist	<input type="checkbox"/> School Information AM = Adoptive Mother PT = Play Therapy T = Therapist	<input type="checkbox"/> Medical Information ATC = Attempted TC RT = Resource Teacher TC = Telephone Call
1-1/ Intake	FM: Emily continually puts objects and her fingers in her mouth. She is strong-willed and indifferent to any methods of discipline we've tried, i.e., behavior charts, catch her being good, time out, “throw toys away” if not picked up. We had to switch the lock to the outside of the bedroom door because Emily wanders at night. She has eaten a whole bowl of candy, colored on walls with markers, and gotten into glue and creams. T: appears to be stuck in an oral stage – possible result of abuse/neglect w/ bio. parents and time in foster care.		
1-2/2 wks	FM reported improvement in putting things in mouth; not interested in teether: “for babies.” FM stated Emily is terrified of the toilet flushing, shower, garbage truck, and the fire alarm at school. She cries and cries after, and the teacher's aide has to hold her. FM stated Emily takes toys apart; takes all clothes off dolls first thing. PT: significant amount of time playing with sand; scooping out of box; pouring like rain from hands; put sand in hair and put face in sand; buried doll in sand: “something coming”; theme of protection and safety; hyperalert to sounds; was aware of sounds in waiting room; alert to therapist's movement and sounds		

Session/ Time Between Sessions	<input type="checkbox"/> Child/Family/Therapist Information AF = Adoptive Father FM = Foster Mother SP = School Psychologist	<input type="checkbox"/> School Information AM = Adoptive Mother PT = Play Therapy T = Therapist	<input type="checkbox"/> Medical Information ATC = Attempted TC RT = Resource Teacher TC = Telephone Call
1-3/1 wk	PT: played with 2 “mommies” in the sand; “Dinosaur coming!”; buried mommies in sand; sprinkled sand “raining” outside box; dollhouse: bedtime “it’s dark outside”; painted on hand; limit set on painting face. FM reports she colors on face and hands, hair with paints, crayons, markers, food – almost like a ritual. Loves water – also face, hands, hair. T: theme of safety and protection; noted she also put her face and hair in sand in first PT session.		
1-4/1 wk	FM reports Emily does not stay in her bed at night; she sleeps on the floor by the door. PT: painted paper and hands; buried 2 dolls in the sand to protect from dinosaurs. T: continues to express theme of fear, safety and protection.		
1-5/1 wk	FM reports decrease in tantrums and misbehavior; she responds to picking her own clothes. PT: buried dolls in sand; dumped the whole box of dolls in; did not play long before announcing “I’m done.”		
1-6/2 wks	FM expressed concern regarding defiance. FM believes Emily doesn’t care when they discipline her. FM reports time outs are not working and they have increased in length to gain compliance. FM states Emily chews clothing and toys, destroys. PT: “behaviors appeared regressive today. She displayed “baby talk”, emptying toys, destructive behaviors. “...due to developmental delay, Emily behaves more like a 2 year old.”		
1-7/2 wks	FM reports improvement with time outs, increased supervision, increased attention. FM reports difficulty between lunch and nap time. “When I send her to her room, she defecates, urinates, and tears the sheets off the bed.” PT: short attention span; able to show mad/happy faces.		
1-8/2 wks	FM learned additional information about Emily’s first 9 months: She states Emily had cocaine in her system at birth. Emily and her brother were repeatedly found outside their apartment by a neighbor who would take them back to their apartment. One day no one answered. The neighbor took them to her apartment and called the police. The police broke in and found Emily’s birth parents “passed out with lines of coke on the table.” Emily was in foster care from 9 months to 2 years. FM added that she was hospitalized for 2 weeks when they first got		

Session/ Time Between Sessions	<input type="checkbox"/> Child/Family/Therapist Information AF = Adoptive Father FM = Foster Mother SP = School Psychologist	<input type="checkbox"/> School Information AM = Adoptive Mother PT = Play Therapy T = Therapist	<input type="checkbox"/> Medical Information ATC = Attempted TC RT = Resource Teacher TC = Telephone Call
	<p>her for malnutrition; she weighed 18 pounds.</p> <p>FM reports tantrums are decreasing, 3x/week but last 45 minutes to 1 hour. “We have to hold her. She bites, slaps, spits, and wipes her nose on our arms.”</p> <p>FM reports she lasts for 15 seconds in a 4 minutes time out.</p> <p>FM reported Emily destroyed her toddler bed. She slept on a sleeping bag for 3 months. They bought her a double bed for her birthday. One morning she climbed between the box spring and mattress and bit out the lining. When FM asked her what happened, she said “I break my bed.” FM reports Emily is locked in her room due to night wanderings and other incidents of destructive behavior. However, she can call to FM to come when she wakes up. FM reports she pulled back the carpet and tore the foam padding. FM reports Emily can play well with either brother, but not with both at the same time. FM reports she can only sit for 5 minutes of play. She states she will play with “30-50 things” in a 20 minute span of time. She cannot sit through a movie. She can sit at the table for a half hour even if finished eating; she will play with her plate. She will not sit through a whole book, even a shortened version.</p> <p>T: Mother appears to have above average parenting ability and ability to cope with Emily’s behaviors. Emily’s behaviors are likely the result of neglect and abuse, however, they are interfering greatly with her home and school environments. Mother reports she will stay in same preschool level due to inability to stay still. Emily’s moods at times appear uncontrollable, non-regulated. She is functioning at a lower developmental level, especially emotionally.</p> <p>Referred to psychiatrist.</p>		
1-9/2 wks	<p>FM reports Emily destroyed her room during nap time. She cleaned it up by herself within 30 minutes as best “as a 4 year old can.” Emily sat through story when brothers were sent to their rooms.</p> <p>T: Mother’s main concerns are emotional regulation and attention. Gave FM the 14 Guiding Principles of ADHD; recommend filial training.</p> <p>Appointment with psychiatrist scheduled in 3 weeks</p> <p>FM reports they found out Emily had pin worms approximately 10 days ago; Behavior and sleep have</p>		

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	significantly improved since then. FM plans to check for nerve sensitivity in her ears.		
1-10/2 wks	FM reports Emily is still having destructive behavior at home. Over the weekend, she stripped her bed, shredded the mattress protector, and used her urine to have a tea party with her baby doll. FM reports the mattress was soaked, the wood frame was wet, and the carpet was wet. She states Emily removes her clothing during this behavior. FM reports they had stopped locking the door, but Emily wandered again, so they have been locking it again. FM reports if her clothing has the littlest hole, Emily will pull the thread until she is able to rip it apart. She reports Emily shredded a dollar that was in her change purse; FM found it under her mattress. FM reports the teacher says Emily is destructive of paper, takes toys apart, puts some things in her mouth, but is listening well and completing tasks.		
	TC 6 days after 1-10 w/FM: appointment with psychiatrist moved up one day; diagnosed RAD; prescribed medication to help her sleep, possibly Risperdal; referred to a different therapist.		
	TC 7 days after 1-10 from FM: she is hesitant to start over with a new therapist. She wants to try filial therapy		
	TC 11 days after 1-10 w/FM: she reports she and her husband are keeping logs of behavior. In the past week, Emily has had 3 days with no time outs. In the first few days with the new medication, Emily soaked the bed, but has been fine since. She has gotten up 2x: once she got into things, but the 2 nd time she fell asleep on the parents' bedroom floor. FM reports one incident of Emily eating the carpet pad again. FM states they're not sure if Emily has changed or if they have.		
1-11/27 days	Filial Group 1: FM described Emily as "spitfire." She described destructive behaviors. Discussed lying behaviors.		
1-12/1 wk	Filial 2: FM reports Emily's level of emotion increases so quickly and easily. She states many issues take place in the car.		
1-13/1 wk	Filial 3:		

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1-14/1 wk	Filial 4: FM was attentive to Emily in play session video and used the skills taught, e.g. tracking, reflecting feelings, returning responsibility, encouragement.		
1-15/1 wk	Filial 5: FM reports feeling “so frustrated” during this week’s PT. She states Emily did not want the session to end and began throwing toys.		
1-16/1 wk	Filial 6: FM reports Emily tore a hole in her pillow a couple days ago. FM states she fixed it and put a Cinderella pillow case on. At nap time today, Emily tore it apart again. FM reports she found a piece of stuffing in her mouth when she woke her from her nap. She states Emily chews the inside of her lips and cheeks too. FM reports teacher states Emily is doing well in preschool; she is better at being redirected this year. FM reports she is having difficulty getting her buckled in the car line. AM reports appt. with psychiatrist two weeks ago. No changes.		
	ATC 1 day after 1-16 to psychologist to consult. Left message.		
1-17/1 wk	Filial 7: FM reports Emily appears to be getting more moody: She seems to turn it on and off like that, i.e., incident at grandmother’s house. FM asked Emily to put on her leotard for gymnastics, but then remembered she wanted her to go potty. FM states she was agreeable. She went in the bathroom and closed the door; a minute later she opened it and in a completely different mood exclaimed “I’m not going potty.” FM said it escalated to “I’m not going to wipe.” FM says she made a mess and had to have a shower. Then she had a full out tantrum. FM gave her a bear hug and told her to put her head on her shoulder. She states it ended just as quickly.		
	TC 2 days after 1-17: T consulted with the LMHC that the psychiatrist had referred FM to. She stated treatment is “on track.”		
1-18/12 days	Filial 8: FM reports their family is very affectionate. FM reports Emily was playing restaurant during their play session and urinated in the bucket with the dishes.		

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1-19/2 wks (holiday)	<p>Filial 9: AM reports Adoption is final. AM: Emily urinated on pillow of friend whose family was visiting from GA, and then tried to lie about it and blame two of her siblings. AM reports “since the Filial Training began, I feel more relaxed, more understanding of her. Even at home, it’s different. We’ve really bonded. We haven’t had the horrible tantrums we had in the past.” AM expressed frustration in the play session because she wasn’t able to get it right; whatever she did was wrong. T: Emily appears to be showing mom how she felt when she couldn’t get it right.</p>		
1-20/1 wk	<p>Filial 10: AM reports Emily had wet the bed. Later at nap time, she swiped the Chlorox bottle and took it in her room. She went into mom’s room and took mom’s lipstick, but mom intercepted her. T: reviewed play session. Mom and Emily are in close proximity throughout the session – almost like a dance routine. AM and Emily appear to have a closer bond. However, Emily still has unpredictable behaviors at home.</p>		
1-21/9 days	<p>AM reports increased bedwetting. She states Emily is not wanting to eat at school or home; she says “my tummy hurts” but still goes to play. AM says they are able to diffuse temper tantrums. AM states she is protective of baby sister. She is bonded with father. Emily plays with brothers, i.e., choo choo or race cars, but they will not play kitchen. T: AM is attentive and aware of changes in behavior. She displays increased ability cope with behaviors. Recommended increased eye contact and holding of child. AM reports pediatrician tested for urinary tract infection two weeks ago – negative T: referred to pediatrician: other possible cause for not eating may be constipation; is Risperdal causing deeper sleep → to bedwetting?</p>		

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1-22/1 wk	Group PT with siblings T: she seemed to have a shorter attention span, but would return to activities. Interacted with brothers occasionally in sand play, microphone, music. She was helpful to brother.		
1-23/1 wk	Group PT with siblings. T facilitated communication between Emily and older brother when conflict occurred in the sand. T: Emily appeared to seek attention and approval. She became bored and announced “I’m done”, but then became engaged again. <input type="checkbox"/> AM stated pediatrician found no medical cause for bedwetting or eating problems.		
1-24/6 days	Group PT with siblings AM concerned that she is chewing the inside of her mouth until it bleeds. She is also chewing the fingers and toes off her dolls. She has increased appetite; she is always saying she is hungry even at school. AM reports she is still not playing with any one toy for long. AM reports younger sibling appears to be “bullying.” Emily, however, she seems to instigate it at times. T: Emily often plays alone by choice, not because she is being excluded; maintained interest in dolls and art activity for a good portion of session; enjoys music. Recommend AM read When Love Is Not Enough. <input type="checkbox"/> AM reports she rushes through activities at school.		
1-25/6 days	Group PT – directive activities with siblings: relaxation/ calming (bubbles); Simon Says (listening/following directions); power sitting (increase ability to wait and focus) T: Emily had difficulty grasping idea of slowly blowing bubbles. She had limited attention and needed to be redirected. She made effort at activities.		
1-26/2 days	Filial Follow Up Group: AM reports they haven’t had formal play sessions due to moving and illnesses. They’ve had family nights.		

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1-27/5 days	Angry Land with Emily and siblings. AM reports Emily peed in new home. T: played well with siblings. She appears to be using urination as control method. Recommend parents not react w/anger; calmly have her clean up; time out.		
1-28/6 days	Session w/mo. and Emily AM reports Emily is biting her cheek. T: using negative behaviors to seek attention		
1-29/2 wks	Family session AM reports things have been going well – no incidents. She states Emily has had difficulty maintaining her attention a couple times which led to difficulties with listening. T: listening, attention, teamwork skills; role modeled giving choices		
1-30/1 wk	AM reports they have had to strip Emily’s room because she is destroying everything, blinds, pictures, etc. She reports she destroyed a photo album. She had urine everywhere after her nap. Mother reports they don’t even hear her come out, or when she does come out at nap time, and they send her back, she swipes things along the way. She took the knobs off her dresser and they found the screws in her mouth. AM reports she engaged in swiping behaviors during nap time at grandmother’s; she got into the diaper bag. T: behaviors only appear to happen at nap time <input type="checkbox"/> AM reports appt. with psychiatrist; she recommends consult with other therapist.		
	ATC same day as 1-30 to therapist recommended by psychiatrist. Left message.		
	TC one day after 1-30: T consulted with LMHC. She states urination may be way for Emily to relieve anxiety caused by separation from mother at nap time. She recommends increasing touch/contact before nap time and giving Emily one of mother’s shirts. Make sure mother engages in holding 2x/day. Cuddle Emily in towel after bath and then have massage time with lotion to increase touching. Emphasizes all food should come from the mother, even the lollipop from the bank teller. States she may need therapy at various points in her life.		

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	TC one day after 1-30: Discussed recommendations with mother. Discussed referring mo. to another therapist in future if needed.		
	T email one day after 1-30 to LMHC inquiring about taking Emily out of preschool.		
	TC 9 days after 1-30 (8 days after email) to LMHC: recommends if mom could handle it, to keep her home; have someone call once/night, support system with people to help cook, etc.		
1-31/10 days	<p>AM reports they implemented all suggestions except the shirt – forgot. Behavior is better. She reports Emily pulled clothes out of drawers at nap time, but no serious damage. She has made several attempts to come out and swipe things, but father intercepted her each time.</p> <p>AM reports the bath routine takes 45 minutes; she likes the lotion.</p> <p>AM reports Emily began coming in their room at 5:30 a.m.; they get up at 6:00, so it's a cuddle time; another cuddle time before nap.</p> <p>AM states 4 days after incident at grandmother's, she found more items hidden behind the dresser and grandmother's shirt cut up.</p> <p>T: discussed attachment cycle; need for more information and training for parents and therapist.</p> <p>Recommended taking her out of preschool, self-care for mother.</p> <p>Mother will log self-care and identify support system.</p>		
1-32/15 days (jury duty)	Catch Them Being Good game with mother and two siblings; Emily had difficulty waiting her turn and maintaining attention.		
1-33/11 days	<p>AM reports Emily is showing more empathy.</p> <p>T: provided education – need to create connection in neurons not made as infant. Self-care for mother.</p> <p>Recommend continue play sessions between AM and Emily.</p> <p>AM reports she has decreased her expectations of herself regarding what has to be done.</p> <p>AM to call for appointment.</p>		
	TC 3 weeks after 1-33 to AM: reports behavioral problems are increasing. If we don't hold her hand like she's		

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	<p>on a leash, she's into something. She took a staple from her mattress and put it into the outlet; then called out "mommy, there's a fire!" The outlet had sparked, scorched the wiring. Emily had eaten the electrical protector the day before. She keeps trying to pick up 1 year old sister. She can't sit for one minute which is leading to power struggle for time outs; spreading food from plate all over; can't tell her no. We have to put her in her room if we need to do something and can't watch her, i.e., the other day I had to help brother in the bathroom. She will run from us, kick, and scream if she knows we are putting her in her room. We are starting to see some of the facial expressions and movements that bio brother used to show.</p>		
1-34/27 days	<p>AM thinks they may have had a breakthrough. She states her husband sat by Emily and asked why she was doing these things. Emily replied "I'm mad at mommy."</p> <p>AM described an incident the next day: They dropped brother off at Sylvan. Emily repeatedly took her seat belt off. Mother would stop. It took 40 minutes to get home. Mother reports she spanked her when they got home, telling her it's not safe. Mother told her "you need to sit in the chair." Mother sat with her. She took her clothes and shoes off and threw them at mother. Mother said "let's go lay down." Mother reports she had gotten up to go to the bathroom. When she returned, Emily had urinated all over the room, and the speech therapist would be arriving in 30 minutes.</p> <p>AM reports she had visits with her bio. mo. until age 3</p> <p>T: Recommended to tell "her story" to help her differentiate between the two mothers; may be acting out anger toward birth mother as discussed in Facilitating Developmental Attachment by D. Hughes.</p>		
1-35/later the same day	<p>AM came with Emily to tell her the story about her birth parents and adoption -- with adoptive brother and sister present.</p> <p>T: Emily showed no recollection when showed the picture of her birth parents. She appeared distracted and had to be redirected. Afterward, she showed extended interest in playing with the people figures.</p>		
	<p>TC 1 week after 1-35: AM reports she is displaying increasing aggressiveness toward mother. She states father put her in time out and it appeared she wanted to be put there.</p>		

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	ATC to mother 10 days after 1-35; left message for mother therapist plans to meet with another therapist to consult in 4 days.		
	T had consultation 2 weeks after 1-35 with another therapist experienced in RAD. She recommends leaving food in the room, putting the lock on the outside of the door and explain to Emily it is “to keep you safe”, and holding/loving the child when behavioral methods are not working.		
	TC 3 weeks after 1-35 to AM: She states we went to Disney for the weekend and she was absolutely wonderfullittle things here and there, but no melt downs or angry words. There was a notable change in her face when it was time to go home. Maybe we should loosen up at home.		
	ATC to LMHC 4 weeks, 2 days after 1-35 to consult. Left message. Also ATC to AM. Left message		
	TC 4 weeks, 4 days after 1-35: AM reports her behavior is horrible; aggressiveness aimed at mother. She has thrown her glass of water at me. She is concerned that other children may feel confused by difference in discipline with Emily. AM to arrange babysitter and call to schedule.		
3 year, 1 month time lapse			
2-1/Intake	AM reports many of the same behaviors she had 3 years ago. She reports she is not careful; she is clumsy – she just goes. She doesn’t look, and anything in her way gets knocked over. Her eyesight is fine, and she does great at gymnastics and cheerleading. She constantly lies, steals little things from friends at school and the teacher’s desk, and has difficulty coping with change and emotions. She stated tantrums are fewer and don’t last as long. She reported she chews the inside of her mouth till it bleeds and she sucks her fingers. She can still be destructive: she throws her dresser over, kicks walls, chews on her shirts, pulls her own hair, and blames others. AM reported her school performance is inconsistent: one day she can read a passage, another day she looks at the same passage as if she’s never seen it – the same with math. AM reported that the resource teacher (RT) said it is difficult to test her because she is inconsistent.		

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	<p>Medications: Tenex, Risperdal, Daytrana</p> <p>T: continues to display sx of RAD and possible learning disabilities.</p> <p>Psychotherapy note: Brothers don't like to play with her because she sucks her fingers. The three girls play together, but usually [sister's name] will end up crying because Emily takes something.</p>
2-2/1 wk	<p>Mother reported she never shows guilt or remorse and still hides food.</p> <p>PT: Feelings game; she does not appear to recognize her emotions.</p>
2-3/1 wk	<p>Sandtray: Emily reported the lady is keeping the volcano from erupting. She indicated she was on the mountain with other people.</p> <p>T: Appears some danger is lurking behind the fencing. There is a snake hidden by the rocking chair. The lighthouse and bridge over the water may symbolize hope; the alligator is close to the lighthouse and the statue of liberty. Sandtray is organized and not too cluttered.</p>
2-4/1 wk	<p>Played game Stop, Relax & Think.</p> <p>T: able to stop on command during game, but not as quickly in the playroom. She had difficulty reading the cards in the game, i.e., the word "say" was "yes." Possible dyslexia? She had difficulty coming up with responses and planning/problem solving. She does not know how to make herself feel better.</p>
	<p>TC two days after 2-4: AM reported it has been a struggle with her from the time she gets up. Incident with blue popsicle... she lied and would not say it was hers.</p>
	<p>TC four days after 2-4: AM stated we never know what Emily we're going to get. She can change in a second and it's hard to know what triggers it. AM stated at cookout on July 4th she was hyper, could not sit still or be calm. They removed her from the group and she was able to regroup. Sunday she would not sit in the car. Yesterday she was a little better and today has been o.k.</p> <p>T: recommend AM keep monthly log to look for triggers/antecedents and also track for possible hormonal cycle.</p>

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2-5/1 wk	Blue Day Book-- things that make her blue: brother picking on me; sister stealing my princess stuff; mommy and daddy making me clean my room; Ways to cheer self: mommy gives me a present; brother gives me a dollar; everyone is being nice to me – giving me hugs and kisses; color a picture; play Wii.
2-6/1 wk	Ways to cheer self continued: cleaning the books by herself; singing or listening to music; telling herself to clean this room; and cleaning grandmother’s playroom
	Email AM sent before session 2-7: She spent night with grandparents and did well. Made comment to grandmother that she did not like one of parents’ adult male friends. Mother not sure why. AM reports several changes in behavior between trying to be helpful and having tantrums: trying to get a bottle when she heard her sister cry – she’s been off the bottle for over a year; calling when she heard her cousin get hurt at gymnastics; tantrums when told it would be time to get out of the pool, when woken up, outside when told couldn’t go in yet – only swam for 2-3 minutes, after speech therapy with trigger unknown, anytime asked to do something. “Turning her feet and walking on her ankles.” appt. with psychiatrist day after session 6; stopped the Tenex and started Intuniv – does not know the dose off hand.
	TC before 2-7: AM reported she is not chewing as much. Observation that she has a desire to be a caregiver/parent, but not to be parented.
2-7/1 wk	Emily reported she was tired. Attempts to engage her were unsuccessful. She appeared exhausted and unable to concentrate. Ended session early.
	TC six days after 2-7: AM reported she has a really good day, maybe a day and a half, then she has a day out of control, then a so-so day, then back to good for 2 days and repeat. AM reported she thinks new medication may be better. She notices a reduction in behaviors and melt downs.
2-8/1 wk	bibliotherapy: lying PT themes: feeding (restaurant); nurturing baby doll, i.e., asked therapist to feed and hold

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2-9/1 wk	Session included brother; topic anger. Emily was unable to identify changes in her body accurately; able to identify her behaviors when angry; she believes anger is bad/can't be controlled.		
	T email after 2-9: provided info on topics covered in session. Homework: Anger tracking Chart; asked about other chart to track her behaviors/antecedents		
	Email 2 days after 2-9 from AM: The only thing I have noticed with Emily is really that she can at most have 2 really good days (meaning AT MOST 2 whining fits, but nothing serious, fits that can be quickly diffused). Then, it's 2-3 days of very hard stressful on everyone days with her. Everything is a fight. We do know that if she is up past 8:00, it's going to be a miserable day the next day!		
	T email 3 days after 2-9 follow up questions for AM: what is different about those 2 days: more sleep? More down time, or less: planned activities or free time? Everyone home? What is she doing on those days – playing alone? Together? Helping you? Recommended asking her how she feels about those “hard stressful days” and what would help. Asked if having family meetings.		
2-10/1 wk	No response from AM on email/did not speak to before session. Emily told therapist she kicked her wall when she was angry. She had difficulty identifying her feelings when playing Anger Solution Game.		
2-11/1 wk	Emily reported getting angry 4 times; she stated she slammed her door. PT: Emily began the session knocking cardboard blocks to the floor; she appeared to be looking for the T's reaction. She then played play-doh, went to the puppets, changed her mind, checked the cash register drawer, went back to the puppets. She threw the puppets toward the T after saying “hello, what's your name?” She then drew on the dry erase board before announcing “I'm done playing. It's a mess.” Appears indicative of the mess she leaves at home. May be acting out to see the response of the T and if it feels safe.		
	TC two days after 2-11: will have same teacher she had in 3 year old class; does well with her homework until she gets tired		

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	<p>T email four days after 2-11: asked AM for update from email not responded to (7b) and update on anger chart, family meetings</p>
	<p>email four days after 2-11 from AM: I have not seen a pattern with her outbursts regarding possibly linking it to her hormone cycle. She does not respond well at all to being called into her room to clean up or told to pick up a mess...she reacts very defensively when being told authoritatively what to do...I have to figure out how to come across differently to her... she immediately gets confrontational and defensive in her reactions with everything that is not in her favor or not in her control...many times I need to leave the room during a fit for my own sanity, and she will purposefully do things to try to get me to come back...kick her closet door (which usually then falls to floor), slam the window blinds until they fall...now I hear the sound of her doing these things, I know what she is doing, and I know what will happen if I don't go back in...the closet will be on the floor, there will be a hole in the wall, the dresser will be flipped (whatever she is kicking she will continue until it is broken, flipped, or whatever). So, I struggle with should I go back in immediately when I hear those sounds, but then I feel she is in control then, and has gotten me back in there on her terms...if I don't go in... if I wait until she is calm, which is usually after the destruction... then we have more mess to clean and she has still won...but then, for every fit I can't hold her and calm her, and baby sit her to be sure she doesn't destroy sometimes she is too out of control for my strength... we haven't been able to find the diffuse button yet. We did have a breakthrough fit...I told her to draw a picture of why she was mad at dinner... thinking back I then realized it was all in front of me but I didn't see it all happen like she had... she wasn't able to tell me initially with words what was upsetting her...But I was impressed that she was able to tell me what really upset her...now I need to be more aware. The anger chart I think is helping them realize when they are angry... I was not consistent in reminding them to do the bubbles, but we have a good routine now...We have not had a family meeting...I honestly forgot...</p> <p>My to do list: be more aware, have a family meeting, blow more bubbles (for the kids, but might calm me too!).</p>

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	<p>TC morning before 2-12: AM reported she started screaming when she gave her 10 minutes notice to finish playing. AM reported she walked on her ankles, shrunk her shoulders, and whined and groaned. She states she took the glass of water by her bed and poured it over her head, then complained about being all wet. AM used reflective listening, reflected feelings and tried to let her come up with a solution. She changed her clothes. When AM left, she took a shoe with a black sole and put 5 marks on the wall. waiting for county psychologist to receive documents before discussing an IEP.</p>
<p>2-12/6 days</p>	<p>Visual imagery exercise to increase relaxation; problem solving intervention: story of friend who had difficulty going to bed and cleaning her room; her solution was “tell her mom to be nice.” AF gave anger chart at end of session. Reported they were not diligent in tracking behavior.</p>
<p>2-13/1 wk</p>	<p>PT: constructive activities. She appears to seek mastery of activities. She quits activity when it doesn’t turn out the way she wants. She often appears to hurry through activities, i.e., cutting, drawing. Short attention span.</p>
	<p>AM email two days after 2-13: I have noticed (which I probably should have taken note of long ago...and I think I did somewhat) on the nights I knew AF would miss the nighttime routine and bedtime I actually would feel myself get uptight about it for one reason...Emily. On those nights she is horrible about 90% of the time, and ends up in bed much earlier than the other kids. I have asked AF if it’s the same when I am gone, and he said about 50% of the time she is good and helpful when I am not there, and the other she is VERY difficult and ends up in bed.... There clearly are the nights that we are both here and she is just as bad. Maybe I am really thinking into it because it’s much harder to deal with when you have to do it alone. O saw me hit a breaking point...and left the room, and started to cry after putting Emily in her room for hitting A and spitting at her, and taking the sole of a shoe to the wall many times. O then ran to Emily’s room and screamed “shut up Emily!” So, any room on your calendar for one more of mine? It’s the deliberate defiance that is so frustrating, and that it takes so much to deal with her, and when I am trying to get the other kids settled...she does more to deliberately get to me. I try to give her other things to do, or have [her] get a book, so that I can settle the others and come back to her with my full attention, but that was no good. The other night I tried settling her first, but when I left</p>

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	<p>her room to do the others, she started slamming her door, slamming the window blinds, and that was her first time marking up her bedroom walls with the sole of her shoe.</p>
<p>2-14/8 days</p>	<p>Session with parents alone. Parents report if they are away from home, there will be one night that she will misbehave on the weekend. They described an incident at the maternal aunt’s house. At bedtime, she got into the bag AM left in the room. She got into the sanitizer, denied when asked, then blew up “it wasn’t me; you don’t like me; I hate my family; why are you being mean to me!” for approximately 20 minutes. Discussed possible triggers, i.e., tone of voice. AF reported a calm voice may trigger more than a normal voice. She appears to have more behavior problems when she is out of her routine – at aunt’s, away for weekend, not in bed at usual time, in morning. Recommend 1: try to improve morning routine by waking all kids at once; have contest to see who is ready first, 2) when she makes threats, reflect feelings/desires; do not leave room if can be helped, 3) give her cuddly at bedtime as substitute till dad gets home, 4) let socks be the school’s problem, 5) pick breakfast the night before</p>
	<p>TC five days after 2-14: T requested psychiatrist call regarding destructive behaviors</p>
<p>2-15/6 days</p>	<p>Session included brother. Emily was active and energetic throughout session – doing cartwheels and back bends. It was difficult to direct her attention to activity. She noted the chair by the couch and asked “Is that your time out chair?” She appears to perceive that she gets in trouble often. Emily asked brother his opinion of their teacher. She expressed that the teacher is “kind of mean.”</p>
	<p>AM email five days after 2-15: Emily has become increasingly difficult...she changes from nice to mean in an instant...but is always looking for a way to be deceitful, or do something she shouldn’t...and when she is caught which is 99%...because she usually tells on herself through actions, or she’ll say something that is suspicious...It doesn’t matter our reaction. I can approach it with no intention of getting her in trouble, or I can state it as fact to her... I can stay as calm and mello [<i>sic</i>]...and she still freaks. The past week has been all day every day is a fight with her.</p>

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	<p>It is now coming out in [sister's] play: This evening I was cleaning up dinner and [sister] was playing in living room by herself. She lined her dolls up, and listening to her I figured out they were in the car. She was having a cute conversation with the dolls, and then she stopped and turned to one and said, "you have to have a seat belt on, put it on, I will wait." (It was calm, but actually very assertive voice). Then she got him from where she was sitting and went to the doll, and said "You have to have a seatbelt, and then she made the sound of a seatbelt clicking, and motioned like she was buckling the doll... it actually caught me by surprise, but it's an everyday thing in our car... Emily takes her seatbelt off, kicks [sister's] chair.</p>		
2-16/1 wk	<p>Session included brother. Emily stated she got in trouble a lot. Brother confronted her on lying about her intent to give him a candy; in this incident she was not lying, but she did admit that she does lie.</p>		
2-17/1 day	<p>Session with parents alone. Parents reported she has outbursts when she is given instruction or correction of her behavior.</p> <p>They reported she lied at school and told everyone AM was having a baby.</p> <p>AM reported she appears to get confused when telling a story and does not always get the facts straight.</p> <p>AM is concerned about her future after hearing a story about a person being sentenced with a long history of mental illness. She worries that Emily will get pregnant or end up in teenage juvie hall. - Sister is acting out scenes in play reflecting frustration and anger with Emily.</p> <p>Discussed extremes of behavior, i.e., need for independence and then need to be babied. Parents reported she is scared to turn on the shower, reason unknown. They reported she startles easily when someone comes around the corner. They reported she appears to be out of touch with physical pain: she does not feel pain from hot water or pain from biting her cheek.</p> <p>Parents reported they are still waiting for the county for testing.</p> <p>AM reported she met with teacher last week. She has not implemented too many of the accommodations on the plan because Emily seems to be performing except for reading. The RT does reading with her.</p> <p>Discussed performance inconsistency and behavior at school.</p> <p>T: behavior appears to be indicative of her trauma history. She appears to have dissociative symptoms, i.e.,</p>		

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	numbing, startle response, fears.		
2-18/6 days	PT session included brother. Emily engaged in solitary play creating money, puppets, cutting. She painted 2 pictures. She gave up on her name. She painted her hand. She tried to engage her brother in play with the kitchen and guns/masks to both be bad guys.		
	ATC 8 days after 2-18: left message for RT		
2-19/8 days	<p>AM reported when she went to wake Emily up, she found she had defecated and wiped it all over her clothes and comforter. AM reported she giggled about it. AM reported she had her help clean up the mess, i.e., take comforter to the laundry room, etc. She states she got more defiant with each instruction. She began jumping on the bed, hitting the ceiling fan. When AM stopped that, she began emptying her drawers, tried to knock her dresser over, yelling, "I hate you!" AM reported she spanked her. She stated Emily looked at her and said "you spanked me" as if wondering why. AM told her "yes, I did, this is unacceptable behavior." When AF came in, she got defiant again. When she was told to get ready for school, she stated, "I'm not doing it" repeatedly. She was not dressed. AF told her "I will put you in the car and take you to school naked." Emily responded "but all my friends will see me." She got dressed, except for shoes and socks which she made sure her AP knew she didn't do. AF put her in the front seat so she couldn't unbuckle her seat belt or hit her siblings even though it is usually a reward to sit up front. AM reported other kids were really good this morning. They reported Emily told her brothers what she did as if she was really proud, but she didn't want her friends to know when her AP told her that her brothers might tell.</p> <p>AM reported she feels controlled by her.</p>		

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	<p>T: It appears that her misbehavior is at a time when it's almost impossible to have an immediate consequence. Parents feel if consequence is to miss cheerleading, then it affects other teammates. Recommended that if it did, then they would be upset with her, creating a natural consequence.</p>
	<p>T email same day as 2-19 to AM: Please confirm medications/dosage. Reviewing whole chart again. AM responded with medications: 10 mg Daytrana patch a.m. 3 mg Intuniv a.m. 3 mg Melatonin p.m. 2 mg Risperdal p.m.</p>
	<p>T email two days after 2-19 to AM: Trying to consult with a psychiatrist colleague. If cocaine in system when born, why not removed right away? AM responded: DCF reported to me that she was cocaine addicted at birth when we took custody. However I requested her birth records a few months ago directly from [the hospital] and there is no record of the cocaine with her. I can give you a copy of her birth record too. The week has had its moments. She gets so angry so quickly about doing routine things... brushing her teeth, cleaning up after self. I asked her to clean up the computer desk, where she had left a mess of DVD's, papers, crayons, etc. She screamed no, and went in her room and put a hole in her closet wall with the heel of one of her dress shoes. AF was gone last night playing softball, and she was really good until I gave her warning shower time. She hit A, and we ultimately ended up in her room. I wrapped her like a taco in her bed spread and just held it closed until she stopped screaming and flailing. (and I held A too...I was sweating after the 45 minute meltdown!) But, I said to myself this is ridiculous. So, I stood up... and said loudly but with really no emotion "Emily your fit is over. Follow me to the bathroom, wash your face and hands. (She did). I said brush your teeth. (She did, then she put her hands under the faucet, which I thought she was going to drink the water that was pooling in her hands... nope she splashed the mirror, and counter... I didn't react, just passed her towel, and she cleaned it, but</p>

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	<p>watched me. I said foolow [<i>sic</i>] me to the computer desk... she did. I told her to clean up the crayons. She did. I told her to clean up the DVD. She did. She asked if was going to bed, and I told her yes. (She has a slumber party to go to on Saturday... I am weary about letting her go. I may let her go, but not spend the night.) Anyway, she asked if she was still going to [friend's] birthday, I said she had to show me that she wanted to go by not having a fit and going right in to bed. She did and was asleep in 5 minutes. This morning she was actually really good.</p>
2-20/13 days (therapist out for 1 wk)	<p>PT: Emily wanted to make a craft. She used all the pipe cleaners, but did not create a finished product. She started to draw a picture, but threw it in the trash. She presented with irritable affect. She appeared to be easily frustrated, unable to organize her thought process to produce the product she had in mind.</p>
2-21/next day	<p>Session with parents alone. They reported she had a freak out week. They reported they did let her go to the slumber party. She snuck brother's DSI game and broke the stylus. When asked, her attitude was "whatever." Parents reported weekends are hard if we have a low key day at the house. She likes going to the soccer/football field because she can bounce. AF reported her favorite thing changes from week to week.</p> <p>AM reports some days she does well with homework, but other days she shreds it. Some days she dumps her backpack all over; other days she doesn't.</p> <p>T: she does not seem to be affected by consequences, and parents appear frustrated that they do not have a motivator that is consistent. However, it also appears family may benefit from more specific rules and chores.</p>
	<p>T email after 2-21 same day to AM: Consulted with psychiatrist colleague. We think may be a dissociative disorder. Plan to email her psychiatrist. Children cannot be diagnosed using the same criteria for adults. Asked mother to look for "changes in personality", i.e., calm to aggressive; changes in abilities, i.e., can do math one day, but not the next; seeming loss of memory of personal information. Requested birth records. Inquired about foster care and why she only weighed 18 pounds when they got her, and no one did anything before then about her weight?</p> <p>Consultation with another therapist: once parents sign the consent for a psychological evaluation, the county has to begin the process within 60-90 days. It could take 6-9 months to complete the process.</p>

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	<p>AM email same day as 2-21 to T: will email birth records... She had a distinct change tonight. She actually was very good all afternoon and evening. She asked if she could start to draw. I said yes, She began to draw and then about 5 minutes into it, I asked her to clear her dinner mess because it was right where she was coloring. That made her flip. She tore her paper into shreds, flipped the kitchen garbage, and completely lost it. When we took custody, no one seemed concerned because her height and weight were proportional. She had a physical last spring, we didn't discuss any physical concerns.</p> <p>I am following up with [RT] on where we are with her paper work and at what stage we are at with her educational and psych testing</p> <p>next appointment with her psychiatrist in 2-1/2 months</p>		
	<p>School meeting two days after 2-21 with AM and RT: RT reported she is not seeing the behaviors mother describes at school. She presents Math material to Emily before the teacher does it in class, and she seems to be catching on more quickly. She reported Emily almost panics when reading is involved, i.e., directions. She reported she is become more fluent with reading: she still has difficulty with "wh" and "th" words. She does not perceive any symptoms of dyslexia, but most likely a processing disorder. RT reported she does appear to "check out" at times and she is a "people pleaser."</p>		
2-22/6 days	<p>Color Your Feelings Activity: able to identify feelings and situations; able to complete craft when structured provided.</p>		
	<p>TC eight days after 2-22: left message for AM - therapist ill, need to reschedule</p>		
	<p>TC 13 days after 2-22: AM reported they had a pretty good week, i.e., 3-4 days with no destruction. Emily was helpful when mom was not feeling well. AM stated she told Emily to come to her when she wants help and she would show her how to do things. AM reported some defiant, sneaky, and lying (about little things) behaviors. AM reported last night it was a "huge ordeal" to go to bed. She states it happened suddenly, like snapping your fingers. Emily had her bath, put the laundry away, and AM said "let's get your meds", "let's sit down", and "boom." AM said Emily went to her room and slammed the door. AF wanted to go in, but AM requested he wait</p>		

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	to see if she would be able to cope on her own. They could hear her begin to kick the wall, so they went in. Rescheduled appt. for 1 week.												
	TC 20 days after 2-22: AM ill; rescheduled appt.												
2-23/3 wks, 3 days	<p>AM reported Emily had a meltdown at cheerleading on Tuesday. She stated the coach commented, “that wasn’t Emily at practice today.” AM reported Emily was “not her” for two hours.</p> <p>AM reported she has been tracking behavior to determine if there is a cycle. She stated her behavior at home has been awful this week. She stated someone ends up in tears, usually herself, and that Emily has usually gone to bed because of a fit.</p> <p>Parents completed the Child Dissociative Checklist. Emily had a significant number of symptoms.</p> <p>AM reported she had a TC with Emily’s teacher yesterday. She discussed with her that Emily does spelling with mom and gets them all correct, but then gets a “0” on the test. The teacher told AM Emily was doing flips with 3-4 other girls on the playground. While the others kept running, Emily came to the teacher with the biggest smile on her face and said “nobody will play with me.” The teacher redirected her to the slide and then asked “why don’t you go play with the girls over there?” Emily acted like she hadn’t played with them already, and said “o.k.” AM reported she saw the RT yesterday and she said “Emily has been different all week.” RT told AM that she was more easily frustrated and had higher levels of frustration. The RT told AM Emily will usually try when she puts a paper in front of her, but this week she said “I can’t do it. I’m not doing it.”</p>												
	<p>Email 10 days after 2-23 (due to holiday) to psychiatrist -- important statements: As you probably are aware, treatment does not seem to have had any effect up to this time. The parents have consistently told me that discipline of any type does not seem to be effective either. I have been suspecting that Emily may be dissociative... I met with the parents ... and Completed the Child Dissociative Checklist with them. ...Based on her continuing destructive and unpredictable behavior, is there any modification to her medication that might help? Her parents report they have not noticed any changes with the medication she is presently taking. We are wondering how much sleep she gets as her mother reports she “hears everything.” She knows if her sister is up</p>												

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	in the night, if mom gets a drink, etc. Requested psychiatrist call me.		
	TC 10 days after 2-23: AM reported Emily had a good week. Yesterday was a little tougher as it was less structured. AM reported she still attempts to be sneaky and deceitful. For example, she asked for a cookie, but she took 6 instead of 1. When AM asked her, she denied it, then said “o.k., fine. I did it, but it wasn’t me.” Recommended AM take away her fear of getting in trouble, make it safe to admit by using humor when appropriate.		
2-24/12 days (holiday)	<p>Emily reported she doesn’t remember her birthday last year, Christmas, or yesterday. She stated she remembered Thanksgiving and friends/relatives of mom’s with piercings.</p> <p>Attempted discussion to introduce how people may go to another place in their mind and not remember things. She appeared unaffected by discussion.</p> <p>She seemed upset at not being able to remember. She wanted to switch topics and activities – slap jack, Santa. Emily tried to make Santa, directing the therapist and mother to make parts of him, but had difficulty making the pieces fit – much like the pieces of her life. She abruptly stated she wanted to leave. Then she stated she was hungry – may be due to increased anxiety over activity.</p> <p>AM visibly teared up during session.</p>		
	ATC after 2-24, same day, to psychiatrist; left message		
	Voice message after 2-24, same day from psychiatrist’s assistant: left message to have AM to call for earlier appt. to adjust meds		
	TC after 2-24, same day, from AM: got refills/appt. in 1 wk		
	TC one day after 2-24: AM reported after last appt., AF took Emily home. He told AM she was tired, like she was emotionally drained.		

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	<p>AM noted how her mind did not appear to stop while she was in the session. She appeared to be struggling within herself. She went from one thing to another thing, and was all over the place. AM reported feeling sad and scared. She stated, “it was out of my control to watch her.” At home, AF could see she was “emotionally gone, frustrated.” She couldn’t do anything, not even get her shoe off. AF had her lay down for a bit. Then she was able to do some homework. When AM got home, AF left with brother. AM was making dinner, and Emily “lost it” seemingly over the type of pizza. AM reported she flipped the table, tore up what she was working on, and ran through the kitchen. AM reported she caught her and hugged her. Emily screamed and tried to bite her. She tried to clear the counter and kick the walls. She yelled, “you’re hurting me!” AM replied, “I am not hurting you. I’m protecting you. Let’s go here and calm down.” AM carried her to the bedroom. Emily kicked the door frame or bed post and told mother she had hurt her two times. She continued to fight mom. After she calmed down, she had a shower, ate the pizza, and said, “mommy, I’m really tired. Can I go to bed?” AM reported yesterday was pretty good. She stated Emily fell on the playground. She got mulch stuck in her hand. AM was at school, so she checked in on her at the nurse’s office. Mother reported when they got home, they were getting ready for the parade. Emily had speech, however, it ended early as she became upset thinking she would get left. She shut down. She was good at the parade. AM reported she has never had a “major rage meltdown” over playing with the kids. She stated she has slapped the two girls when they came in when she was in the middle of a rage, but no marks were left. AM reported she met with Emily’s teacher. Teacher told her it is difficult to monitor what she eats as she is not on lunch duty. She can monitor whether she has brought her lunch or needs to purchase it and ask aides to make sure she is not dumping her tray. Teacher reported she eats a snack in the morning at recess and another snack in the afternoon. AM stated she would put in extra snacks that are healthy. Teacher stated she will eliminate Math homework as it has become a major source of stress and frustration. AM states she sent the torn papers in a baggie to the teacher. She reported teacher told her Emily turned it in with a big smile. RT will work on Math one day/week with her. She works with her 3 days/week. She has a 38 average in Spelling. They are going to</p>

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	<p>move her back to 1st grade book. Teacher reported to mother Emily is showing a side of herself that is more easily frustrated. She reported she slapped herself in the face and is tugging on her hair; she shows no reaction to hurting herself. AM expressed concern that she does not want modifications to lead to retaining her. She stated she is social and has some close knit relationships, and the same group is on her cheerleading squad. The teacher and RT agreed. AM reported she is at a kindergarten level developmentally for writing words and sentences. AM reported Emily went to pediatrician for her physical. He is concerned about her weight as it has dropped from 53 lbs. to 47 lbs.</p>		
	<p>TC one week after 2-24 from AM: They had a really good weekend. They were really busy on Saturday. Mon and Tues were really good. Her first breakdown was on Wed. It was significant, but there was no destruction. AM thinks eliminating homework and other accommodations are helping. Emily feels very confident with the 1st grade spelling book appt this afternoon with psychiatrist</p>		
	<p>Fax one week after 2-24 received from psychiatrist: Pt.s therapist questions whether Emily might have Dissociative D/O. Axis I: 313.89. Medication: trial Zyprexa to see if improving sleep will improve emotional/behavioral control. Will decrease Risperdal to 1 mg hs (further tapered D/C if pt shows improvement with Risperdal [Zyprexa]) and continue Daytrana 10 mg. Will taper off Intuniv (2mg x 1 wk, 1 mg x 1 wk then D/C) as mom doesn't think it has helped.</p>		
	<p>TC 8 days after 2-24: Therapist will be out of town next week. Following week is Christmas. Schedule after holiday. AM reported psychiatrist considers dissociative symptoms to be part of RAD diagnosis. She stated following changes in medication: eliminate Intuniv; keep Daytrana patch at 10 mg; keep Melatonin at 3 mg; begin to eliminate Risperdal; add 2.5 mg Zyprexa to help with deeper sleep; increase every few days until reach proper dosage.</p>		

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	<p>TC 26 days after 2-24: AM reported Zyprexa made her behavior worse. Her heart was racing through her chest and she was extremely hungry. AM reported she stopped the medication two days ago and left a message for psychiatrist. AM reported she was “horrendous” at Christmas Eve Mass. She stated they were driving home and her head kept going from “side to side” and she had a “look of fear and panic.” AM stated she has also been experiencing extreme thirst. AM left another message for psychiatrist inquiring if thirst could be due to rise and fall of sugar levels. She is also going to contact pediatrician regarding a glucose test. AM reported when she is in a “full out fit”, she has been yelling at them that they’re strangers and she needs her real family. This has happened three times over the break. Scheduled appt. w/parents. AM to pick up book.</p>
	<p>AM email same day, 26 days after 2-24 to T: psychiatrist discontinued Zyprexa and back on Risperdal 2 mg; will have blood work tomorrow</p>
	<p>TC 4 weeks after 2-24: AM reported Emily had lab work yesterday [per psychiatrist] and a sugar check/urine sample at the pediatrician’s office. Pediatrician reported both were fine. Waiting for blood work results. Confirmed Risperdal 2 mg at night. AM to pick up book, <i>Parenting the Poorly Attached Child</i> by Jonathan Maletz, MA three days before appointment.</p>
2-25/1 month, 5 days	<p>Education provided to parents. DVD - begin nurturing holding technique. Parents expressed concern about the other children’s reaction to Emily’s fits and how to deal with behavior in the car. AM reported lab results came back o.k. Mo. states she is not sure why triglycerides were high, but psychiatrist was not concerned about it.</p>
	<p>TC five days after 2-25 from AM: sibling is home sick; rescheduled appt</p>

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2-26/1 wk	Parents did not finish watching DVD. Continued in session. Parents reported Emily appears to flip out 2-3x in the afternoons for no apparent reason, i.e., brushing her teeth can set her off. AF holding her increased her outburst initially, but then when she is calm, she will say “I need a hug.” Parents report her bio. brother is scared when she has her outbursts and worried that AF is hurting her.		
2-27/one day	Session with parents, siblings without Emily. Explained to children what parents will be doing to help her.		
2-28/4 days	Education. Worked with parents to explain to Emily. Emphasized self-care for parents and time for each other, i.e., date. AF will look into alarm for room.		
2-29/9 days	Parents reported they explained holding to Emily. They reported they are seeing improvement. They reported one major happening at gymnastics. Emily had gone by a friend. When AM went to move her things, she discovered Emily had taken her brother’s DSI and stylus. She had put stickers from the dr.’s office on the DSI and chewed the stylus. Discussed reframing responses from DSI incident. AF reported he found an alarm, but it needs batteries. Parents have not arranged a date yet. Parents appear to be consistent with holding and are increasing use of reframes.		
2-30/1 wk	AM reported incident two days ago. It appeared to be precipitated by the snack machine being broken at cheerleading, but occurred when she got home and dinner was on the table. AM reported she had 6 meltdowns between 3 and 7 p.m. at home yesterday. AM appeared to be exhausted and doubting program. AF was encouraging her. He appears to doing self-care, however, AM is not focusing on her self-care. Recommend AM find ways to care for herself, i.e., have coffee with a friend, read. Follow through with getting battery for alarm for door. Set up behavior charts.		

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	<p>AM reported her class went to the nursing home yesterday. When they got back to school, AM realized she had things that didn't belong to her. She told her she needed to return the items. Emily became stubborn and resistant. AM held her. AM informed the teacher. She reported that she deteriorated in the afternoon in her ability to do school work.</p>		
	<p>TC one week after 2-30: missed appt</p>		
2-31/13 days	<p>Teacher called AM last week regarding incident where Emily and another student were in the same bathroom stall.</p> <p>AM discussed school incident during nurturing holding time; led to discussion of good touch/bad touch. AM expressed concern that she likes to hold older boys hands and have them carry her at cheerleading. AM reported biological grandmother contacted her to see Emily. She invited her to Emily's cheerleading competition this past weekend. AM expressed concern that they left without saying goodbye to Emily and that her present husband has a history of possession of crack cocaine.</p> <p>AF reported she was really good at the competition and on the school field trip to the State Fair.</p> <p>AM reported decrease in lying; she stated it is more likely during resistance holding.</p> <p>AF reported she asks for hugs sometimes now.</p>		
2-32/8 days	<p>Parents reported she had a rough time after 6 p.m. yesterday. They reported she may have been upset with her best friend.</p> <p>Parents reported they got a battery for alarm, but they have not installed it yet.</p> <p>Parents reported they have not had a date night, but they enjoy time alone after the kids go to bed.</p> <p>Parents reported they have asked Emily how they can help when she is being resistant. She says "be nice" but she is unable to describe "be nice" in behavioral terms.</p> <p>Parents appear to be more comfortable with use of holding and are able to maintain a positive demeanor.</p> <p>Recommend parents discuss with Emily what "be nice" means during regular nurturing holding times and provide examples.</p>		

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	<p>Parents will decide to activate alarm or implement chore this week.</p> <p>AM reported there will be a meeting in one week with someone from the county to discuss progress and needs for additional help.</p> <p>AM reported Emily had stolen hand sanitizer from other students two days ago; she had done this two weeks ago as well. She wrote letters of apology.</p>		
2-33/1 wk	<p>Parents report they hooked up the alarm; it has not gone off</p> <p>AM talked with her about “being nice”; AM reported she seemed disinterested.</p> <p>AM reported Emily was up later than usual due to party, and they paid for it on Sunday. She reported she had a meltdown at church.</p> <p>Parents reported decrease in number of resistance holding times, but not the length of time she needs to be held before calming down.</p>		
	<p>Sent email same day as 2-33: letter to school guidance counselor with information about Emily’s history, diagnoses, dissociation and copy of the Child Dissociative Checklist for meeting in two days. Recommended evaluation occur over 3 different occasions spaced at least one week apart as her abilities seem to fluctuate.</p>		
	<p>Email one day after 2-33 from guidance counselor: clarified meeting tomorrow is with AM and speech and language therapist; team meeting with school psychologist will be one week from tomorrow to review interventions and sign permission to evaluate</p>		
	<p>Sent email one day after 2-33 to AM: asking if my presence needed at meeting in one week</p> <p>AM responded she did not think so</p>		

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2-34/8 days	Emily reported she does not like it when her brother or kids at school hit. She likes when her mom is being nice, and she likes to play Chutes and Ladders. First session with her in 3 months; re-established rapport Emily was confused about where therapist had been T: provided two books for parents to read to her		
	TC twelve days after 2-34: AM reported behavior good over break. She stated Emily had one tough day. She woke up crying that night for mother. She was aware the alarm on her door would go off. She told AM “my door will scream.” AM reported she was warm and said her ear hurt. AM took her to the pediatrician. She had a severe ear infection in both ears – undetectable by her unresponsiveness to pain.		
	TC 2 weeks after 2-34: AM had to cancel appt.; school called to come get her; she will take her back to pediatrician as antibiotic almost gone		
35/19 days	Session with Emily to assess ability to concentrate, frustration level, emotions. She was able to name some emotions, but not able to describe specific times when she had an emotion. She remained focused on activity with encouragement and direction. She was able to tell “girl was going to a party”, but unable to give details about it.		
	TC day after 2-35: Discussed session progress with AM. Recommended they have her practice telling about “a time she remembered.” AM reported they had an incident after Emily had visit at pediatrician’s office for her ears. She had a meltdown and was kicking her legs and feet when her foot got twisted in the slipcover. AM could tell her cry changed from tantrum to hurt. She reported her foot swelled up. When AM asked Emily what she did, she cried, “I was mad! I was mad! I was mad!” AM took her back to pediatrician’s office. She sprained her ankle.		

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2-36/1 wk	<p>Emily drew painted two pictures demonstrating feelings of closeness to AF. She stated she likes it when her father “holds me.” She stated she would like her mother to do it also.</p> <p>Puppet plays expressed themes of “being lost and needing a friend”, “her brothers not being nice”, and “people not being nice.”</p>
	<p>TC one week after 2-36: AM forgot appt.</p>
2-37/2 wks	<p>AM reported AF started job, and they are moving this weekend.</p> <p>AM stated evenings are still difficult and Emily appears to be using food when she is bored.</p> <p>Emily appeared to have difficulty with nondirective activities.</p> <p>Emily appeared to be in a younger stage, i.e., painting on her hand and then placing on paper.</p> <p>She was “bored” getting the people and house ready for a story; activity not completed.</p> <p>She appeared to do better with question game at the end, but was more interested in throwing the puppets.</p>
2-38/9 days	<p>AM reports Emily has been pulling her hair at school, scratches herself, and slaps herself. She reports they moved into their new house over the weekend. She stated Emily did well going to bed on Sunday. She was off school on Monday, and AM reports she was a “snot.” AM stated possibly due to the move, dad starting his job, and the holiday all at one time. AM stated she tried to engage Emily in activities to help, but she lost interest quickly. AM told her she could pick an activity, but she responded, “I don’t want to do anything.” She played a game with her sister that ended in a fight. Sister hit her; she hit sister back. AM reports 3 big meltdowns and whiny behavior. AM expressed concern that sister is upset by her behavior. AM overheard her telling maternal grandmother that AM has to hold her to keep her safe, and sometimes has to spank her. AM reported she was “horrendous” at bed time on Tuesday. She reported nurturing hold turned into a resistant hold when AM finished song and said “time for bed.” She reported Emily flipped out saying “I’m scared.” AM reported she blocked the way when AM went to turn out the light. AM put her back in bed, but she ran to the hallway when AM turned the light out. AM reported they left the door to the hallway open and put a nite lite in the room. AF has not been able to do holding times due to hours of new job. AM reported she is trying to do them</p>

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	<p>consistently at night.... AM reports Emily paints her hands up to her arms at home too. She states she will ask permission to paint her hands, but she always takes it further. AM states she notices Emily acts younger sometimes at home and school. She states she appears to act 9 or 10 when she is cheerleading, but she notices a change in her the “second she gets in the car to go home.” AM reports she becomes whiny and oppositional, i.e., to putting seat belt on, uses baby talk.... AM reported she still demonstrates lying behaviors. She stated her “first answer to things is a lie”, i.e., “homework finished?”, “eat food in your lunch box?”</p> <p>Recommended avoiding questions that can lead to lies and using statements such as “show me your homework.”</p> <p>AM reports all academics were modified at IEP meeting. She gave consent for educational, IQ, and emotional testing. They will test her before the end of the school year.</p> <p>AM reports same medications. She reports the Daytrana patch brings her to a “functioning level” at school, i.e., can stay in her seat, be redirected, and complete tasks.</p>
	<p>TC six days after 2-38 (note out of order in chart placed in chronological order here): Guidance counselor reported current service plan is for language. She will be getting re-evaluation to determine if additional services are needed within 60 days. The only additional services she could get from county while attending private school is afterschool tutoring.</p> <p>Guidance counselor reports they did not want to have a functional behavior analysis done because they do not see the behaviors at school that are happening at home and it could delay the process even longer in getting help for her.</p> <p>Guidance counselor reported she observed her in class for reading. She reported she played with her hair and sucked her fingers while the teacher was reading. She did not know to turn the page unless she saw other students turn their pages. She was unable to complete the worksheet about the story afterwards. The teacher gave her an alternate assignment and she was unable to complete it either.</p> <p>Psychotherapy note: some stealing behaviors; zones out in class</p>
	<p>TC one week after 2-38: AM left message to reschedule.</p> <p>Emily broke her thumb and has an orthopedic appt today.</p>

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	<p>TC one week after 2-38: AM stated Emily had a temper tantrum at bedtime Friday night. She got her thumb tangled in the bedspread. When AF tried to help, she freaked out more. So he left her alone. She was jumping and tugging when her cry changed to one of pain. AF held her and calmed her.</p> <p>AM reported bedtime has been a battle every night since they moved into the new house. AM reported Emily has to go for a walk or take a shower to help transition when she first gets home, and that has been working. She stated they go through the bedtime routine, leave the door open, keep the night light on, she has her cuddly and book, but it is still a problem.</p> <p>Recommend AM talk to her about what she thinks might help her.</p> <p>In the morning her hand was swollen so they took her to the ER for an x-ray. They said it was sprained and taped it. By the time they drove from the ER to church, Emily had the tape off. AM reported they taped it back up, and she had it off again by night. AM reported she was uncomfortable and whiny on Sunday. AM took her to pediatrician on Monday. He sent her for an x-ray; it was broken. The orthopedic surgeon put a cast on for the next 2 weeks.</p>
2-39/2 wks	<p>AM reported she is called "Lizzie" at school. She started that this year.</p> <p>AM described incident of Emily decompensating when it was time to pick up toys.</p> <p>AM described differences in parenting Emily and siblings as well as differences in parenting styles she and AF grew up with.</p> <p>AM reported her family did not use a lot of yelling, grounding, redirection, or talking. They gave the children a lot of chances and usually just a look would do. AM reported this works for 3 of their children. She reported it does not appear to work for Emily and her BB.</p> <p>Recommend AM videotape outbursts.</p> <p>Recommend include sister in session as AM reported she is being impacted by Emily's behaviors.</p>
	<p>Email same day as 2-39: therapist asked AM if she asked Emily what would help at bedtime?</p>

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	<p>Email same day as 2-39: AM responded that she got very generic “I don’t know” type answers. AM reported she videotaped Emily tonight. AM reported “Haven’t mustered the strength, courage, etc. to watch it back.” She stated “she wasn’t thrilled about it and pretty sure it made it worse. However, not nearly as bad as what we have seen.”</p>		
	<p>Email one day after 2-39: T asked AM for clarification on her statement and to continue recording for a week.</p>		
	<p>Email four days later after 2-39: AM wrote “I think it escalated the fit quicker than usual, but it definitely didn’t reach the extreme that we sometimes see. Tonight I think the weekend has caught up to her and as we arrived home and got ready for bed, she completely fell apart when she was asked to pick up the clothes off her floor ... and of course the battery has died on the camera.”</p>		
2-40/5 days	<p>AM reported Emily would not help clean up before school, so she didn’t let her dress down. AM made her wear her uniform. Emily refused to get out of the car because she didn’t want the others kids to see her – until she noticed some of them also had uniforms on. PT with Emily and sister. Emily began writing name on chalkboard, but then looked around and stopped.</p>		
2-41/1 wk	<p>Session with Emily and sister. They participated well and cooperatively. She was able to let sister lead. Emily appeared confused at the beginning of the session. Two times she responded with a color when the question had nothing to do with a color. Emily initiated a game of “who is the nice girl.” One time she asked “who is the mad girl.”</p>		
2-42/9 days	<p>Played game to discuss good/bad behaviors. Emily became “bored” after 30 minutes – improvement in time she maintains attention. She worked on a craft (fashion design) and crumpled paper. She appears to have negative thoughts about her own work – prefers what others make. AM reported she described Emily’s anxiety to psychiatrist. She prescribed Buspirone. Mother will call to schedule.</p>		
	<p>Email received from AM 13 days after 2-42 regarding scheduling appt. ATC to AM; left message.</p>		

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	ATC two weeks after 2-42 to AM; received voice message from AM same day.		
	TC two weeks, four days after 2-42. Scheduled appt.		
2-43/3 wks	<p>AM reported her behavior and fits are unpredictable; it can be something trivial. She reported at least one tantrum or fit daily, often in the car.</p> <p>AM reported Emily can eat 3 helpings and come back 10 minutes later saying she's hungry.</p> <p>AM reported they are doing nurturing holds.</p> <p>Provided education about dissociation and need to accept all "parts." Discussed origin/purpose of some behaviors.</p> <p>Recommend assuring Emily of "safety in the now" and acceptance during fits.</p> <p>Provided material for AM to read on dissociation.</p> <p>AM reported Buspirone increased to 15 mg (5mg – 3x/day). She stated it helped the first week, but not now.</p> <p>Psychotherapy note: picks fights – mainly with [sister's name] – names, throws things at. AM reports incident on way home from school in the car. Emily was crying "don't go this way! Don't go this way!". AM couldn't understand why because it was the only way to get to their house. As we talked she realized that Emily had seen a car accident by the gas station when she was on her way home this past weekend with her AF; a baby had been injured in the accident.</p>		
2-44/6 days	<p>AM reported Emily appears to be on edge all the time. She is always alert to sounds. She has always had the uncanny ability to watch something done once and to be able to do it, i.e., unfasten the safety gate, pinch buttons on car seat strap. AM reported she knows where they are going when driving if she has been that way before.</p> <p>AM stated she will look to the side as if she heard someone speak to her.</p> <p>T: Assess for auditory hallucinations.</p>		
	TC six days after 2-44 to AM: missed appt		
	TC six days after 2-44: AM reported new medication made her drowsy. Scheduled appt. in 8 days		

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	<p>TC two weeks after 2-42: therapist requested move appt to next day.</p>
	<p>TC two weeks, one day after 2-42: AM reported babysitter cancelled. Rescheduled.</p>
<p>2-45/3 wks</p>	<p>AM reported Emily was compliant and pleasant with grandmother when she took her for downtime during camping. She lashed out at AM when she came to swim, but couldn't due to thunder/lightning. Grandmother is going to keep her 3-4 nights/week for summer.</p> <p>AM reported all 3 girls spent night at grandma's on Sunday. As AM was getting the suitcase together on Monday, out falls a stack of money (two dollar bills). Emily lied: "I don't know why [brother] put that there." Then she said, "I took it from [brother's] room." Then, "[sister] put it there." AM asked grandmother if it was hers. AM had Emily tell grandmother. Consequence is that she could not come over for a couple nights. AM reported it didn't seem to affect her.</p> <p>On the way home, she threw a fit in the car. She asked AM, "What are we going to do?" AM responded "go home, eat lunch, play puzzle, sit with mommy." Emily replied, "I don't want to sit with you. I didn't do it. I didn't steal the money."</p> <p>AM reported she had a 45 minute tantrum. AF did nurturing hold. AM stepped in and said to Emily, "stand up, your dinner is on the table. You will sit and eat and take a shower." Emily stopped her tantrum. AM reported she thought to herself "if she is being a baby right now, she may be hungry and can't tell us."</p> <p>T: Emily's behavior may indicate switching. AM reported change in her face, drastic switch from compliant to not compliant, usually with mother. Possible another part does not accept mother? Is not feeling accepted by mother? Mother is having difficulty coping and remaining empathetic.</p>
<p>2-46/1 wk</p>	<p>Emily noticed nesting dolls. She identified their faces as happy, nervous, scared, scared, mean, and angry. She wanted to make a craft; made a caterpillar with pipe cleaners.</p> <p>Beach Ball Feelings Toss: She expressed surprise that AM said she went to bed well.</p> <p>She reported watching a movie called "angry ____ poop."</p> <p>Emily described being scared when she had a dream there was blood on the floor and no one believed her. She</p>

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	<p>named all family members as disbelieving, but “God believed me and then He died.” Emily played with the medical kit: AM was “ill” and therapist was “happy.” Emily asked to have a bunny, then asked to have a magazine, then asked to have a book. She played with play-doh; she wanted to eat it. AM set a limit. Emily then tried to shoot AM with dart gun. She wanted to make something for sister, but could not complete it. Emily appeared relaxed and cooperative at beginning of session. She demonstrated intact memory for pipecleaners she had used more than 2 months ago. She was able to discuss her feelings. Her behavior appeared to change after discussion of the movie and dream. She became less focused and increased activity moving from one play activity to another. She appeared to be testing AM with the play-doh and by shooting at her. AM remained calm in setting limits. Emily appeared unable to organize herself to complete the craft at the end of the session that was similar to the craft at the beginning.</p>
	<p>TC one week after 2-46: AM stated Emily had hard time sleeping since last session. She keeps checking to see if parents are there. AM reported that Emily told her before speech therapy at 9:30 a.m. yesterday she was really tired. When she finished speech, she wanted to play. She was fine. She got whiny at lunch. AM told her they’d have lunch and then lay down. Emily lost it around 1:00 p.m. She was screaming “you don’t like me! You don’t like me!” repeatedly. AM tried to hold her, but it wasn’t working. AM reported she was starting to not feel well, and she knew her patience was low. AM put Emily in her room and then AM sat in the hallway with the door open crying. AM reported Emily tipped her dresser and stripped her whole closet. She reported she completely trashed her room. AM stated brother commented at 6 p.m. “mom, do you know we’ve listened to her scream for 5 hours?” AM reported she was still that way when AF got home. AM reported psychiatrist increased Buspirone to 7.5 mg 2x/day and 10 mg at night yesterday. She states she was still up last night.</p>
	<p>TC eight days after 2-46: AM is ill; reschedule when better</p>

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	TC two weeks after 2-46: AM stated she is recovering from pneumonia. She reported she asked Emily during and after a fit if it was Emily. She stated Emily told her an imaginary friend dared her to do some things.
2-47/2 wks, 6 days	<p>Emily presented a puppet show about a dog named Buster meeting a friend. She incorporated the theme of another animal coming and “being mean.” Another dog named Buster came to help. When asked, she reported that there were two dogs named Buster. One dog knew about the other, but the other one did not know about this one.</p> <p>AM asked Emily to do a show about what happened the other night. Emily and AM played out this show. Emily’s brother hit her on the head. She tipped the chair over and had a fit. Her daddy took her outside so she could calm herself down. She reported her friend, Bob, came to help.</p> <p>Therapist asked her to draw a picture of Bob. She reported that Bob was bald and naked. She gave various ages for Bob. It appears he may be a baby.</p> <p>Emily wanted to make a book. She titled it “My feles...Bob pigts” [My feelings...Bob pictures]. She initially wrote “Lizzy” before the word “My”, but then colored over it. She stated that Bob dared her to do things. She stated he is there at night when she has trouble sleeping, but he does not help.</p> <p>Emily reported she went to her orientation today. She is excited about school starting tomorrow [a Wednesday].</p>
	TC eight days after 2-47 AM called in crisis. AM reported since the second day of school, it has been a fight from the moment she wakes up until they put her to bed. AM reported she is destroying everything. She shredded her bedspread. She has been chewing her bottom lip since Friday. AM stated her lip looks like a canker sore and she has two holes in her tongue. AM stated when she gets mad at AM, she is biting herself. AM reported it is affecting the other children. She reported Emily is pushing her younger sisters down. She screams and hits anyone who is walking next to her. AM reported she was trying to calm her down when her brother walked by. She screamed, and brother grabbed her hair – he was upset at how she was treating mother. AM stated no punishment affects her. She reported Emily has mosquito bites that won’t heal because she is digging at them. She reported Emily got frustrated with her homework yesterday and ripped it up. She stated she was biting her lip and the blood dripped on the paper. AM wrote a note to the teacher across the top of the page to

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	<p>explain the state of the paper. AM stated I don't think I can do this anymore.</p>
<p>2-48/ 8 days</p>	<p>Met with AM for 2 hours.</p> <p>AM stated she has been in tears each night by the time AF gets home from work.</p> <p>AM reported Emily was a "brat" in the car on the way to the gym Tuesday. She told her she would have to sit by her while AM taught class because of her behavior. AM stated she sat there, but she was "clearly not happy."</p> <p>AM stated that Emily is aware of her environment and her surroundings; she doesn't lose control in public. M stated she holds it together at grandparents' home. She stated Emily had one fit when grandparents were at their home. Grandparents left because they couldn't watch her do that.</p> <p>AM reported that Emily got upset at gym today because AM offered to help her with her backpack as items were falling out as she walked. Emily responded with "garbled" language. When AM tried to take the backpack off her shoulder, she exclaimed, "I need that!"</p> <p>AM reported when Emily is deep in a meltdown, she will fight with dad.</p> <p>AM reported speech therapist has "seen her at her worst." She stated once she realizes the speech therapist is there, she stops.</p> <p>Observed behaviors on video clip AM brought – details in email to psychiatrist. Regressed behavior observed especially in her language, e.g., "nop it! Instead of "stop it" and use of grunts/groans.</p> <p>Plan to contact psychiatrist, explore ways to restructure after school time to help transition. Possible alternatives may be afterschool program, family support, other respite programs, mother's helper. Plan to contact agencies and teacher.</p>
	<p>Email morning after 2-48: T described regressive and rageful behaviors seen on video clips to psychiatrist: ... In the first video Emily is making moaning/grunting sounds and yelling "nop it" (stop it—which she can normally pronounce). She used the same language in the previous video I viewed. She is in her bedroom. She bangs the wicker waste basket several times on the floor and wall. She throws all the clothes out of her dresser and off the shelf. There are two shelves (boards) on the shelf that AM reported were there because she broke them previously. She took them and threw them on the floor. She jumps in and out of her bed. She attempts to pull the</p>

<p>Session/ Time Between Sessions</p>	<div style="display: flex; justify-content: space-between;"> <div style="width: 33%;"> <p><input type="checkbox"/> Child/Family/Therapist Information</p> <p>AF = Adoptive Father</p> <p>FM = Foster Mother</p> <p>SP = School Psychologist</p> </div> <div style="width: 33%;"> <p><input type="checkbox"/> School Information</p> <p>AM = Adoptive Mother</p> <p>PT = Play Therapy</p> <p>T = Therapist</p> </div> <div style="width: 33%;"> <p><input checked="" type="checkbox"/> Medical Information</p> <p>ATC = Attempted TC</p> <p>RT = Resource Teacher</p> <p>TC = Telephone Call</p> </div> </div>
	<p>curtain from the window. This behavior goes on for approximately 7 minutes, 30 secs....Surprisingly AM asked her if she wanted a bath, and the behavior stopped abruptly! She said “yes.” AM instructed her to pick things up – which she does very calmly. This takes a few moments. After her bath, AM took her downstairs to feed her dinner [spaghetti]....The next video clip was back in Emily’s room.... “I’m hungry”. The she is tired. Then she wants dad to hold her. He said, “I tried to hold you. You hit me and kicked me.” She says, “I want a taco”....AM asks her if the sores on her tongue hurt. She says “no”, then follows with “yes”.... AM reports that Emily does well socially at school. She reports the kids gravitate to her. She does engage in some “stealing behaviors” – taking other kids’ items.</p>
	<p>TC one day after 2-48: a series of TC calls made to the psychiatrist, teacher, two other agencies. No programs available. TC to AM. She was feeling better. AF got her ready for school today. Explained to AM that while that was positive, ultimately needed to work on relationship with AM so she would let AM parent her. Teacher offered to help with homework 2-3 days/ week after school. She recommended having homework as it would make it harder for her later if she didn’t. Reported Emily appears happy in class. Noticed her scratching her leg in one spot last week and told her “try not to scratch.” Reported she seems to be staying on top of things. Reported Emily goes with 3 other students to RT in the morning for reading. In the afternoon, the RT comes to the classroom to assist. Teacher reported guidance counselor is following up with the county regarding testing. Psychiatrist states “it does appear she is dissociating.” She does not know of any facilities for children. She recommends consulting with another therapist in county and contacting other agencies.</p>
	<p>Email day after 2-48 to therapist recommended by psychiatrist with the same information.</p>
<p>2-49/5 days</p>	<p>AM reported grandmother will keep her overnight on Wednesdays. Speech will be every Thursday.</p>

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	<p>Teenager to help Mon afternoons. Emily wanted to make another book about Bob as she left other one at home. She reported Lizzy is her nickname at school. She stated homework is not a problem, but then said it was. Perhaps one part recognizes there is a problem with homework, but another part does not. AM appeared to have regained sense of peace and calm. AM reported teacher told her they had been discussing families beginning 2 days before AM called. Teacher told AM Emily had shared with the class the “story of finding her new mommy and daddy” because “Mary was too sick to care for her.” Teacher will help with homework on Tues and Fri. added another ½ mg of Risperdal during the day</p>		
	<p>TC two days after 2-49: psychological testing scheduled in 12 days</p>		
	<p>TC two days after 2-49: contacted teen to help AM</p>		
	<p>TC eight days after 2-49: T provided information for AM to contact teen. Discussed structure of time: 1 hour AM and Emily spend in activity of Emily’s choosing/teen with other children; 1 hour teen, AM, all children participate in activity to increase bond in sibling relationship; 1 hour teen to help w/children with homework so AM can make dinner. AM wants to sign release so therapist can speak to SP before the testing. AM completed the BASC.</p>		
	<p>TC ten days after 2-49: AM to see if she had contacted teen to schedule appointment. ATC to SP – left message</p>		
	<p>Email ten days after 2-49 from AM with date/time to meet w/teen.</p>		
	<p>Voice message eleven days after 2-49 from SP</p>		
	<p>Email eleven days after 2-49: therapist to AM confirming appt.</p>		

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	<p>TC eleven days after 2-49 to SP: left message regarding time to talk next Monday.</p>
	<p>Voice message from SP eleven days after 2-49 confirming day/time to talk on Monday</p>
	<p>TC two weeks after 2-49: T provided background info regarding possible traumas to SP; described symptoms: trance like states, numb to pain, tantrums, regression in language and behavior, difficulty planning/ organizing/ maintaining attention, possible alter or imaginary friend, stealing behavior at school, playground incident; SP reported she administered the BASC and Conners.</p>
<p>2-50/2 wks</p>	<p>Emily stated she was surprised she remembered a game teacher from last year taught her – beach ball – colors represent feelings. Emily asked AM and therapist to sit on other side of room while she made a craft; AM and therapist discussed Emotional Regulatory Healing training therapist attended. Emily enlisted our help to twist pipe cleaners. Tried to engage her in discussion about school psychologist, people being mean, being adopted. She appeared to have difficulty talking while doing the craft. She said “let me think about it.” Not able to focus on both or not interested? Emily stated that “Mary was sick, so a girl brought her where she could be safe.” She painted another George Washington picture. Wanted to take a toy bunny home at end of session. Emily remembered working with SP, but said she needed to “take breaks.”</p>
	<p>Consult day after 2-50 w/AM and teen: discussed structure of time teen will be in home Explained to teen behaviors she might observe and what procedure to follow; coached teen in helping siblings to increase empathy toward Emily if outburst occurred</p>
	<p>Text eight days after 2-50: teen will not attend appointment, she “felt comfortable with yesterday”</p>

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2-51/8 days	<p>AM reported Emily displayed different behaviors yesterday morning. She told her to get dressed, and Emily responded, "I can't get dressed. I don't know how. It's going to be backwards if I put it on." AM told her she would help her fix it if it did. AM stated she came out stomping. AM told her to get dressed again. She replied, "I'm too tired." AM told her dad was making her eggs. She stated she didn't like eggs. AM offered her cereal. She stated she didn't like cereal. AM told her no more choices until she got dressed. AM stated she started getting upset, asking her repeatedly, "Is it a P.E. day? Is it a P.E. day?" AM told her "no, it's a red shirt day." Emily stated, "I want to wear a skirt." AM told her to go in her drawer and get one. She replied, "I can't. I don't know how." AM told her she already did this the night before – picking out clothes and discussing it wasn't a P.E. day – and she wasn't going to help. AM reported she thought Emily was going to lose it, but she didn't. She just stated, "I don't have socks." AM stated she was thinking to herself, "I don't know what kid this is, but..." She reported a short time later, Emily came into the room and started walking on her ankles. She flopped to the floor and began picking at her mosquito bite. Her AF told her that her egg was ready. She asked, "Is there cheese in them? I want cheese. I want cheese." AM stated she gave Emily her pill to take. Emily dug in her mosquito bite with it, which grossed her younger sister out because it got blood all over it. AM stated Emily was still whining about cheese in her eggs and then threw her water. AM gave Emily her pill and her towel. Emily asked, "Am I going to eat?" AM stated by the time she cleaned up the mess, it was time to leave, and she did not eat. AM reported Emily got in the car from school acting out of character, i.e., flipping in the seat, doing handstands, and repeated, "I'm not doing my homework" ten times. AM tried to let her know she wanted to tell her something. Emily asked, "Is it something fun?" AM also relayed story about biological brother "throwing sister under the bus" when caught out of bed at aunt's house to demonstrate relationship between Emily and her brother. gave DVD of Emotional Regulatory Healing and 7 copies of chart to track changes.</p>		
2-52/6 days	<p>AM stated she is feeling angry. She feels like she is in a domestic violence situation with Emily being abusive. AM reported she was gone for the day Sunday. Emily was with her AF and younger sister. Emily said dad hit her and pushed her. AM said "That's not what you told me last night." Emily reported she was mean to her</p>		

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	<p>sister. AM reported she was in time out when she got home. She fell out of the chair and accused her AM of tipping the chair when her AM was across the room.</p> <p>AM stated she believes her behavior is on purpose.</p> <p>Explained to Emily affect of neglect by BP on her ability to trust AM to parent her.</p> <p>Emily asked to draw a picture. She drew a picture of her adoptive and biological homes.</p> <p>AM stated Emily tried to sabotage BB on Friday and make him late for safety patrol. She put her uniform on backward.</p> <p>Used nesting dolls to talk about the “baby” inside of the bigger doll with angry feelings.</p> <p>Emily wanted to play with the beach ball. AM commented, “It’s like it’s always new when she plays with it.”</p> <p>Emily commented during play, “I’m a baby.”</p> <p>Emily asked AM if she was crying; she asked therapist the same question at the end of the session.</p> <p>Her memory of behaviors is not accurate.</p>		
	TC three days after 2-52 to speech therapist; left message need fax number to send release		
	Voice message three days after 2-52 from speech therapist with fax number; fax sent and ATC; left message		
	Voice message four days after 2-52 from speech therapist		
2-53/8 days	<p>AM reported Emily does not appear interested in time with her. She told AM she wanted to do what her brother was doing and asked if she was “done spending time with you yet?”</p> <p>AM reported Emily was stealing the snack from her brother’s lunch box at school.</p> <p>AM reported Emily appears to be confused between Mary, her BM, and Mary, mother of Jesus.</p> <p>Addressed AM’s belief from last session that behavior is on purpose vs. switching.</p> <p>Discussed need to accept all parts, calming strategies and self-care for AM; AM appeared more relaxed this session</p>		

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2-54/6 days	Relaxation with Emily; Emily planned and organized craft; called wizard Mr. Prickle Pants – misspelled pants – “piss” <input type="checkbox"/> next week is school fundraiser – next appt 2 wks		
	ATC two weeks after 2-54: left message for AM; received voice message back from AM; TC same day: rescheduled appt in order to prepare for consultation. AM reports Emily has been doing fairly well. She has had some outbursts, but they have ended fairly quickly. <input type="checkbox"/> SP is going to do a second testing due to fluctuations in performance		
	Consultation two weeks, four days after 2-54 with Sandra Wieland, Ph.D. Summary information had been e-mailed before-hand. Confirmed diagnosis of DDNOS and made recommendations.		

Appendix G - Tyler Treatment Summary

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1/Intake	Tyler’s AM expressed concern about his behaviors at home and especially at school. She reports she spoke with his Math teacher yesterday. She and his other teachers recommended putting Tyler on a 504 plan; she told AM that he cried in her class and another teacher’s class. AM reports problems with touching/aggravating other students and cursing. She states he will take the blame when didn’t do anything. They plan to see urologist next week for bedwetting. Tyler also has problems with constipation. The drug, Abilify, had an adverse effect after less than 30 days. AM states she needs to schedule appt. to check liver again. AM had to cancel [MH center 1] appt.		
	TC w/guidance counselor next day: “agitation appears to be increasing as the demands are increasing, and he does a lot of fidgeting”. She recommended 504 plan.		
2/1 wk	Tyler reports he is the “smartest in his class”. He reported he did not know why he was here, but did say he had some problems at school, i.e., kids tease him, staying in seat, blurting out answers. Conners 3 Self-Report.		
	TC from guidance counselor 5 days after session 2 – Teachers have completed Conners scales.		
	TC-6 days after appt/day before session 3-- AM reported she had to go out of town the week of FCAT; Tyler was in trouble everyday and had silent lunch for the week.		
3/1 wk	Kinetic Family Drawing – family watching t.v. No faces on people; possibly facing the t.v., not comfortable drawing faces, hiding emotions or not aware of them. Discussed anger. Tyler did not appear to be aware of physiological changes when he gets angry. AM reports stomachaches every morning for about a month. AM reports she had to cancel the urologist appt. as she was out of town. She state he has an appt. at [MH center 1]		

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	the next day.		
	TC 1 week after 3- AM reports they had appt. at [MH center 1], but do not plan to pursue as they do not want him on medication.		
	TC 1 week after 3, later that day – AM expressed concern that Tyler “gets up at night, pees on the carpet and the wall.” She reports he did it last night and 2 other times in last 2 months. AM doesn’t believe he does it on purpose. Recommend rule out medical cause. AM reports Tyler has urologist appt. next Mon. or Tues.		
4/1 wk, 2 days	<p>Parents appear aware of differences in expectations, need for consistency, and need to learn other behavioral and discipline strategies.</p> <p>Recommend social activity and increase positive interaction time with each parent; AM will track “annoying and demanding” behaviors to establish a baseline.</p> <p>AM expressed concern that Tyler is not feeling well almost daily, even on weekends; discussed possible connection to constipation. Recommend rule out medical cause for enuresis/ constipation/not feeling well and increase water intake.</p> <p>AM reiterated they do not want Tyler on medication due to concern about physical harm to his body.</p>		
5/1 wk	Tyler reports he got in trouble at school today: he told another student to “shut up” and used other “inappropriate language” (on behavioral reflection form teacher wrote). Identified anger strategies.		
	TC 5 days after 5- AM forgot appointment.		
6/1 wk	<p>AF reports Tyler is starting to argue back to him.</p> <p>Discussed 14 principles ADHD, need for more frequent and immediate feedback and consequences, breaking tasks down, shaping behavior, being consistent.</p> <p>Therapist discussed AM’s memory problems. [AM also forgot two appointments before the intake.]</p> <p>AM states teacher reported Tyler was aggravating another student and starting to show anger. He was moving a girl’s folder. She asked him to stop, but he didn’t. The teacher intervened. He denied doing it. The teacher told him “I saw you.”</p>		

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7/5 days	<p>Tyler reports he got in trouble at school today in 2 classes and got all privileges removed at home. He reports he was suspended 3x in the past.</p> <p>Tyler reports getting angry 4-5x.</p> <p>Tyler reports he did not practice any of the 3 strategies when he got angry.</p>		
8/6 days	<p>Tyler's homework chart not brought to session.</p> <p>AM states "it is difficult to get him to focus and think when he is angry."</p> <p>AM expressed concern that she may have an authoritative parenting style.</p> <p>AM uses baby talk, e.g., "wakey, wakey".</p> <p>AM reports teachers have begun sending home daily reports of Tyler's behavior/academic performance.</p> <p>Parents expressed concern that Tyler is "pegged" at school – AM states "other kid taps him, he says leave me alone, teacher sees him."</p> <p>AM reports urologist did exam, but no tests; she states when he was going to do the "private exam", Tyler said "no" and started crying; he gave AM info. about alarm system.</p>		
	<p>TC before session 9</p> <p>The teachers expressed they don't believe Tyler wants to misbehave; he cannot control impulses. They report he really wants to belong. They suggest he get involved in a group at middle school where he can have an identity and sense of belonging.</p> <p>Teacher reported got in trouble at school yesterday; not for anger.</p> <p>AM reports enuresis - on carpet in room when he gets up; AM wakes him at 12:30 a.m. & 3:00 a.m. to go to the bathroom; he gets up at 6:00 a.m. up for school.</p>		
9/1 day	<p>AF reports he took day off work and Tyler took day off school today.</p> <p>Tyler reports he doesn't get "sad, sad" at school, just bored; "sometimes he cries when he gets angry".</p>		
10/6 days	<p>Behavior chart for week returned.</p> <p>Parents report Tyler did not listen (rough jumping in pool); argued with 6 year old; and talked back to an adult at friend's house.</p> <p>AM and AF are aware that they differ in expectations and need to communicate and agree on what the rules will be.</p> <p>The parents repeat rules several times and do not follow through with consequences.</p>		

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11/1 day	Session with Tyler and sister – attention skills, memory skills, waiting/turn taking, sportsmanship, frustration skills, intensity of feelings. Tyler reports he got a check mark for “poor quality of work” because he was drawing in math (figure being smashed by giant hamburger on one side; other side many “talk bubbles” saying things like “I forgot my parachute, etc”.)		
	TC 13 days after 11 - AM Forgot appointment		
	TC 15 days after 11 - AM Forgot appointment; recommended AM rule out medical cause for memory problems as she expressed she “never used to be this way.”		
12/3 wks	AM reports Tyler is going to karate 3x/week. She reports “major improvement” noticed by family and friends: more patience, haven’t seen temper since school got out, listening and focusing more, considering others’ feelings, opening doors for others, not wetting bed (4 days/ gets him up at 1:30 a.m.), not lying. She reported that even last summer, he was not this good; so it’s not just because school is out. Discussed attunement. AM increased insight in how her interaction and responses impact Tyler’s emotional states.		
	TC 6 days after 12 - AM states family was at office at 6 p.m. – appt. was at 6:30; rescheduled.		
	TC 7 days after 12 - AM rescheduled because she has extra kids		
13/12 days	AM reports they did not complete the chart over the last week due to out of town guests. She states Tyler gets angry with his sister easily; doesn’t act 11. Session addressed communication skills w/family, i.e., interrupting, perception checking. Tyler’s perception of his anger is a 3; his sister’s perception of his anger is a 7. AM was aware that Tyler appeared more inhibited in his responses with AF present.		
14/1 wk	Tyler reports he has not gotten all the check marks expected on the behavior chart. He reports he “still improved a lot.” AM expressed that he had improved. AM expressed concern about hygiene. Tyler appeared embarrassed by AM’s comment about hygiene; ABCs /reframed belief to cares about him.		
15/9 days	Homework from previous session not completed. Tyler expressed anger at friend’s younger son who “kept asking me for my stuff.” ABCs with Tyler and AM; cognitive distortions. Communication skills: I statements, blaming.		

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	AM expressed concern about enuresis when Tyler goes camping.		
16/1 wk	AM reports they have not had time to follow up on Tyler's progress with making the bed. She states they "want to do the checklist, but they are always on the go." AM states they "need help with rewards that don't involve parents' time all the time." AM reports she has no time for herself. She states they have decided no matter what happens, they do not want Tyler on medication. Activity to demonstrate prioritizing, working together, communicating, compromising. AM appears to be having difficulty prioritizing. Tyler has increased awareness of his tendency to "take over" project.		
17/1 wk	AM stated homework not completed because friend's daughter was hospitalized. Tyler reports he is tired and grumpy. Reviewed A,B,Cs, discussed automatic thoughts, identified cognitive distortions.		
18/1 wk	AM reports some improvement in impulsive behaviors such as interrupting. She reports fighting with sister decreased. Tyler expressed concern about school being difficult this year. Explored thoughts/beliefs, reframed negative thinking. Tyler demonstrated impulsivity today, but was able to accept correction. He is "embarrassed" when AM corrects him in public.		
19/5 days	AM reports behaviors are better at home, but she is concerned about the school environment. She reports Tyler lied about amount of time he played video game; consequence was no electronics for 3 days. AM expressed concern about Tyler's hygiene. She states he told her he "forgot" to wash his hair, but she doesn't believe him. Tyler reported he did not brush his teeth. Tyler interrupted AM as she was speaking, but caught himself.		
	TC 14 days after 19 - AM had not called to schedule because she had been ill.		
	TC 15 days after 19 - missed appt. TC from AM: She "could not remember whether appt. was today or tomorrow." <input checked="" type="checkbox"/> AM reports Tyler is doing well with school so far. She reports they have to "keep on him for everything." AM states she goes through his backpack after school every day and it is a mess. <input checked="" type="checkbox"/> She states he is starting to complain about some of the kids. AM reports she lost her calendar when she was sick and doesn't remember when the school open house is. Therapist encouraged AM to rule out medical cause for poor memory.		
	3 weeks after 19 - AM, Tyler, and sister arrived 30 minutes late for appt. Therapist recommended AM schedule medical appt. for herself.		

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20/4wks from 19	<p>AM reports Tyler has had no comments about negative behaviors in his agenda. She expressed concern about Tyler getting his work done and turning it in on time. She reports one paper was two weeks late because he couldn't find it. AM states his back pack was disorganized – she states she goes through it with him. AM is receptive to letting Tyler own the problem. She says she doesn't have to stay on him like she used to. Reviewed treatment plan. AM reports Tyler has improved on behaviors, i.e., demanding behaviors, interrupting, and not waiting. She reports he does still do them; “he is impatient.” AM reports she does a “thorough cleaning of Tyler’s room weekly.” Tyler reports middle school is “funner” but “harder” too. He states he has 3 mean teachers. He eats lunch with two other boys. AM and Tyler completed a social skills checklist. Tyler appears to be unaware of his negative social behaviors and other’s perceptions.</p>		
21/1 wk	<p>AM reports Tyler was sick for the past week. They took him to the ER for upper gastro pain spasms. Dr. could not tell what it was; may have been a virus.</p> <p>AM reports she feels Tyler is being “lazy.” All he wants to do is play hot wheels and videos.... AM reports he doesn't follow through with homework or back pack. Tyler reports he feels “groggy.” He states he is having trouble falling asleep. He states “when I get home, I’m not relaxing.”</p> <p>Tyler reported he goes to bed at 6:00 or 7:00.</p>		
	TC 6 days after 21 - reschedule appt.; AM ill		
22/2 wks	<p>AM reports Tyler does not have time to write the homework down all the time at school. She states nothing is being done about 504 accommodations. AM states Tyler always forgets something on his hygiene list. She reports it takes him “forever” to go through his backpack. AM states Tyler complains he doesn't get any “me time”.</p> <p>AM states she is not allowing video games until Tyler brings home a report card with As, Bs, and one C. She reports he brings home papers with 0s. His interim did not have good grades. AM realized this strategy is not working.</p> <p>Discussed how children with ADHD need external reference to help track time, and need to see information to keep it in mind. Discussed how they need more external motivation. Discussed more immediate reinforcement, i.e., use of tickets, verbal praise, hugs. Recommended setting up a schedule for Tyler for after school and using a timer....</p> <p>Discussed with AM that Tyler may need medication if behavior strategies are not working.</p> <p>The therapist e-mailed schedule and checklist.</p>		

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	<p>TC 1 day after 22 - AM reports "I'm done". She states "he lies all the time." AM states Tyler lies about not having homework when he didn't write it all down. She states he doesn't always have enough time to write it off the board. AM states "he will wad up paper in front of me, and say he doesn't have it." AM reports his teacher wrote a note saying she knew he did a paper in class, but he didn't turn it in. AM reports teachers have not said anything about Tyler being disrespectful in class. She states they know he has ADHD and appear to give him some leeway. AM reports he lied about downloading pictures on his cell phone.</p> <p>AM repeated again her desire to avoid medications.</p> <p>Recommended: 1) AM review principles of ADHD/reminded her of principles to forgive herself, her child, and others; act, don't yak, and need to be consistent, 2) AM contact school guidance counselor regarding zeroes/homework. Is meeting with teachers needed? Is 504 plan being utilized? Is Tyler doing well on the work when he does do it?, 3) AM will do something for herself today.</p>		
	<p>TC 5 days after 22: AM reports she left a message at the school, but has not heard back. She will try again. Therapist discussed with AM "lying" by not telling Tyler about his birth circumstances and risks of telling.</p>		
	<p>TC 5 days after 22: later same day: AM reports she tried to call the guidance counselor again after first TC, but has had no response.</p>		
	<p>TC 6 days after 22 - AM reports she received an email from Tyler's critical thinking teacher and a TC from his band teacher. She states they report he was "making gay slurs; almost got in a fight, throwing things." AM reports Tyler told her he "can't control his emotions" – states he "looked ready to cry" when he said it.</p> <p>AM expressed fear about medication due to experience with previous prescription affecting his liver.</p> <p>Recommend AM keep log of all e-mails and phone calls from school. Therapist will try to call the school counselor; appt. on hold until therapist speaks to guidance counselor.</p>		
	<p>ATC same day to guidance counselor. Left message with receptionist.</p>		
	<p>ATC next day to guidance counselor. Informed she is "doing testing all week." Receptionist will tell her again.</p>		

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23/10 days	<p>AM reports the orthodontist said Tyler’s jaw is growing “contrary to normal development”; AM expressed concern that Tyler had a biological brother whose head was “abnormally large.” AM reports changing Tyler’s karate to more self defense due to “bullying.”</p> <p>AM was unable to print the schedule and checklist therapist e-mailed; therapist printed them for her.</p> <p>AM reports she feels like she is “doing it by myself” as she and father have different parenting styles. She reports she rubs Tyler’s back in middle of the night when he can’t sleep.</p> <p>AM has not seen Tyler do any homework, and he has not brought her anything to sign.</p>										
	<p>TC same day, after 23 - The guidance counselor reports Tyler’s has had the following disciplinary actions:</p> <p>23 days ago: tardy –warning</p> <p>17 days ago: The dean spoke to him about horseplay on bus.</p> <p>10 days ago: The band teacher to spoke to his parent to inform her he is becoming a “daily disruption.”</p> <p>8 days ago: Tyler was pulling rubber stoppers out of the frame and throwing them across the room at a student.</p> <p>3 days ago: Tyler was making mean remarks and staring a student down during a nurse presentation.</p> <p>She reports he has the following grades:</p> <table border="0" data-bbox="401 943 997 1089"> <tr> <td>F – Math</td> <td>C – Language Arts</td> </tr> <tr> <td>D – Science</td> <td>A – P.E.</td> </tr> <tr> <td>A – History</td> <td>B – Critical Thinking</td> </tr> <tr> <td>B – Band Wheel</td> <td>B - Reading</td> </tr> </table> <p>The guidance counselor reports he has had 6 absences. She reports he does have a 504 plan in place. It was last updated 6 months ago. Scheduled a conference with the teachers in two weeks.</p>			F – Math	C – Language Arts	D – Science	A – P.E.	A – History	B – Critical Thinking	B – Band Wheel	B - Reading
F – Math	C – Language Arts										
D – Science	A – P.E.										
A – History	B – Critical Thinking										
B – Band Wheel	B - Reading										
24/12 days	<p>AM reports she received a TC that Tyler had disrupted the class and had upset a female student. She states he lied about it. AM reports “father took to closet” [spanked him].</p> <p>Therapist: Discussed homework/school progress with Tyler. He appears to be committed to doing well in school, but acknowledges difficulty keeping organized. He appears to lie to avoid disappointing and/or upsetting his parents. He appears to want to please them. Plan to address different parenting styles by teaching alternative discipline strategies.</p>										

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Conference at school 2 days after 24	<p>Science teacher reported a problem with reading: “Tyler won’t put his book down – gets grumbly; doesn’t turn in assignments.”</p> <p>The P.E. coach stated he has only had Tyler for a couple weeks. He states he struggles socially. He is usually reading in locker room – 60-70 kids there. He received an email that he is having issues with another child.</p> <p>Another teacher stated at lunch he has his hands on other students; provoking other students. He is respectful of the teacher though.</p> <p>His Critical Thinking teacher reports he is a “loner” – no problems with others around him. She states he’s in the back. He does well on tests (“very smart”)/things done in class; sometimes he doesn’t finish.</p> <p>Tyler has a problem turning in work he takes home. She states he has trouble thinking and writing through. He will roll his eyes, but is not verbally rude. She reports an issue with reading his book. She reports he zones out and doesn’t follow instructions. She states he has the option of going to a time out room; he has gone once.</p> <p>The Language Arts teacher reports Tyler turns his homework in. He sits close to the teacher with no one beside him. She states he has to take everything and put on her desk, e.g., his ruler, pencil, etc. He unloads his backpack on the desk next to him. She states if he only has to be told to “stay focused” one time, he gets a gold ticket or candy. She reports he has had problems with another boy since 2nd week school. They are in four classes together, and both boys’ parents are aware of the situation.</p> <p>The Band teacher reports Tyler got along well with 2 others in the class. He reports “small things adding up”, e.g., asked 5-6x to stop talking, rocking in chair, leaning on stands. He asked Tyler if he could give him a silent cue. He reports the gay slur/rubber stopper is the only incident he has had.</p> <p>The school psychologist recommends putting him in an area of least distraction; using the parent portal to track assignments; and positive reinforcement for completing work.</p>		
25/1 month, 5 days later (therapist was out of office/ then Thanksgiving,	<p>AM reports he is failing his classes; he is just reading books. She states he got ISS (In School Suspension). Clt. reports the school has a “no touch policy”. He was “goofing with his friend and ‘play punched’ him.” AM states if he fails this year, she is going to home school him. AM reports she “is not giving up.”</p> <p>Tyler rated his level of happiness a 9 out of 10. He states he “feels like quitting, but he’s not giving up.” He reports he is responsible for the problems he is having. He reports feeling successful at his aunt’s house and tae kwon do.</p> <p>Therapist: It appears that Tyler really wants to please his parents and do well. He appears to be happy in spite of his</p>		

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etc)	difficulties. He displays knowledge of appropriate social behaviors. It appears his impulsivity interferes with his ability to be successful in social relationships and academics. Medication may benefit him. <input checked="" type="checkbox"/> Appt. at [MH center 1] for medication in 2 wks.		
	TC 6 days after 25 - AM forgot appointment. She is sick		
	TC 13 days after 25 - AM called: kids getting sick; asked to have phone session; provider does not allow.		
	TC 19 days after 25 - AM forgot appointment; scheduled later same day		
26/19 days	AM reports she cancelled [MH center 1] due to illness. She has not rescheduled it yet. AM expressed she is still leery of medications. <input checked="" type="checkbox"/> AM states she has gotten several telephone calls and emails from Tyler's teachers. She states one teacher has said he is "tuning out." AM reports Tyler took legos to school which the teacher took, and AM refused to get back for him. <input checked="" type="checkbox"/> AM reports they have removed all privileges, i.e., no t.v., IPOD, toys; cell phone only for school to let AM know he is on/off the bus. AM reports his bedtime is 8 p.m.; sister's bedtime is 9 p.m. AM reports he is not doing any school work, including his robot. She reports she lost the paper to get on to the parent portal and she is embarrassed to call the school again. <input checked="" type="checkbox"/> Discussed AM's forgetfulness; encouraged AM to go to the doctor.		
	TC 9 days after 26 - cancelled appt.; AM and Tyler are sick		
27/4 wks	<input checked="" type="checkbox"/> AM states Tyler has appt. at [MH center 1] in three days. She has accepted that he may need medication. <input checked="" type="checkbox"/> AM reports "he has given up." She states he "is not doing work, lying, won't listen, does his own thing, doesn't care." AM states dad took him for a "talk in the closet – 1 pop – talk some more." AM reports they "took away his birthday." She states they told him "you are not contributing to the family; it's not all about you." AM states at school he "totally ignores his teacher when she is talking and reads his book." AM states nothing is working. She wanted to use "shock therapy" – taking away everything, spanking, thought of telling him he was adopted. AM also states she believes Tyler "wants to do good, to love and be loved". AM reports he had difficulty with some of the kids socially [at camp]. Tyler stated "some kids wanted to beat him up." Tyler said he got a referral on Friday for not having his i.d.; he's gone through 20 i.d.s. <input checked="" type="checkbox"/> Session with AM and Tyler. Discussed Tyler's behaviors and parents' interventions. Discussed lack of progress due		

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	<p>to illness/infrequency of sessions. It appears that AM has fluctuated in her thoughts about Tyler's behavior. She concludes that he is not doing it on purpose and medication will help. Tyler appears to try to remain hopeful and is motivated to correct behaviors but he continues to have difficulty staying focused and on task. AM will contact therapist after [MH center 1] appt.</p>		
	<p>TC 8 days after 27 - AM reports appt. at [MH center 1] with psychiatrist is in one month. She states Tyler is staying after school on T/TH for 1 hour for tutoring/to complete homework. AM states Tyler was angry about doing it. He was crying at dinner "I know why you're doing this – so you can get rid of me!"</p>		
28/2 wks	<p>Tyler reports he has been getting good comments in his agenda: "good day"; "did work"; "paid attention. He reports he didn't write homework down today because AM picked him up early because "I'm sick and my back is burning." AM states he had time to write his homework down. Tyler raised his voice when AM's perception re: time to write homework differed from his. Tyler states raising his voice is "the only thing that shuts up my boys" at school. He appears to have insight that it is a learned behavior. AM reported something happened Sunday. AF left, but he came back. He made a commitment to stop raising his voice. AM states tutoring is helping, but he's not doing his homework on off-tutoring days. Family will work on a family mission statement. DVD provided</p>		
29/1 wk	<p>AM reports she has not seen Tyler's agenda this week. She states, however, that he has been doing better. AM reports she needs to get with the guidance counselor to get a tutorial on using the parent portal. AM reports they did not do the family mission statement. They watched the DVD last night. AM reports Tyler's sister "makes a fuss... on purpose" about him. Discussed present reinforcers that are motivating vs. past reinforcers. Discussed Tyler's volume/rate of speech. AM is using a hand signal to increase awareness for him. Discussed learned behavior. Discussed dynamics with sister. Discussed prioritizing. AM questions the need for medication as Tyler appears to be improving. She appears to understand that even though he is improving, he is still not functioning at a level similar to his peers.</p>		

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30/1 wk/2 days	<p>AM reports they did not discuss the family mission statement, but they all like the idea. She reports no time to watch the DVD either. She reports she is going to contact the guidance counselor for a tutorial on the parent portal. AM reports Tyler is trying to “cut tutoring days short.” She states he tells her he does not have homework so he doesn’t have to go.</p> <p>AM reports Tyler broke the rule about time for playing video games, so took away for 4 days.</p> <p>Discussed family schedule and priorities. Discussed communication problems in family, i.e., jumping to conclusions, misperceptions. AM gained insight in session that what family was doing does not match what she perceives their/her priorities/values to be. It appears that due to all the outside activities, there is little time for authentic interaction between family members and the opportunity to instill sense of responsibility.</p> <p>Provided communication handouts and DVD.</p>		
	TC 6 days after 30 - AM forgot appointment.		
31/1 wk	<p>AM reports that AF got the code for the parent portal from school. However, she states they still need to schedule with school for a tutorial on using it.</p> <p>AM reports they completed their Family Mission Statement, but she didn’t bring it. She states they watched the DVD, but did not discuss the questions. They will do that tonight.</p> <p>AM reports Tyler got one A, Bs and Cs on report card. She states he is not focusing at school.</p> <p>Discussed AM’s concerns about Tyler “fitting in.” She expressed concern that he made a friend who does not have a good family environment. Discussed differences in parenting approaches and communication.</p> <p>Homework: read communication handout from previous session; discuss DVD questions with AF; bring family mission statement and report card to next session.</p>		
	TC 4 days after 31 - AM requested reschedule appt.; Tyler has FCAT tomorrow; scheduled 1 wk		
	TC 7 days after 31 - AM called to see if appt. was next day – not for 4 more days		
	TC 11 days after 31 - rescheduled to next week		

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before session	TC before 32 to AM: Confirmed appt.; requested AM bring copy of report card; discussed book for Tyler. She expressed concern that Tyler is failing. She reports he is not doing the work in class; he will do the work at home and not turn it in; he does not bring home the papers he is supposed to do; he “will lie” about not having work, about teachers not letting him come in to complete it early. AM reports she and AF have not discussed the DVD questions. She states she can get the book requested. [MH center 1] prescribed Clonidine .1 mg (1/2 a.m. and ½ p.m.). AM reports she thinks it is the one that worked before after 1-1/2 weeks, but it does not appear to be working now.		
32/14 days	AM reports she forgot to bring the report card. Tyler reports he is failing 4 classes and passing 4 classes. AM is considering homeschooling. He expressed belief that his AM could have “a conference” tomorrow, and he could do his work over the break. Discussed academic progress and impact on future. Tyler expressed the thought that he “could do a business like his dad does.” Tyler does not appear to have realistic expectations/beliefs about the importance of his academic success and procedure for getting a conference. AM appears to believe behavior is intentional. Tyler, however, appears sincere in his desire to do well. He presents with cheerful mood/affect. He does not appear oppositional.		
	TC 7 days after 32 - to [MH center 1] – informed nurse meds not working		
	TC 11 days after 32 - missed appt.; AM reports she has been sick. She apologized for not calling. AM states the medication is not working. AM states Tyler has had a “skin burning” sensation on and off medication.		
	TC 18 days after 32 from AM: She is waiting for Tyler’s appt. at [MH center]. She expressed concern medication is not working. Informed AM that therapist had informed the nurse. Coached AM to explain concerns to dr. regarding past medications and side effects.		
	TC 18 days after 32 from AM after appt. at [MH center 1]. She expressed disappointment and frustration with dr. She reports they left with “no new prescription, no appointment, nothing”. She states the dr. said she did not know what to do because she didn’t have the previous records; AM states she signed a release for the neurologist when she was there one month ago. AM states the dr. said she needed blood work; AM states she told her they did that the last time they were there. AM expressed frustration that the dr. asked her what she wanted her to do. AM states she will need		

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	to get a different dr.		
33/20 days	<p>AM reports she is trying to get appt. at [MH center 2]. AM expressed concern that Tyler was not on medication; however, she stated she did not notice a difference with it. Tyler's math teacher said he wasn't agitating classmates like he was, but academically there was no difference. Tyler is playing trumpet and goes in early to learn. Tyler's uncle is tutoring him on math on Wed. AM recognizes that homeschooling may not be the best option as it may lead to increased tension in the home and decreased socialization for Tyler.</p> <p>AM expressed concern that Tyler is withdrawing from family. She expressed concerned that Tyler and father "do not connect." She reports that sister gets attention from father because she "demands it."</p> <p>AM appears to be struggling with priorities for Tyler in that she feels guilty he has to have tutoring and come for counseling. She expressed that "karate is the only fun thing he has."</p> <p>Discussed with AM first year of life to rule out RAD. She reported "his birth mother was at the bar drinking; his room was the size of a closet, he would cry, and no one would come." AM reports when they first got him, "he would not look into our eyes, and would not hug." AM expressed concern that if they told him he was adopted, he would become depressed or feel he is not wanted. She states the best scenario would be he could be connected with his family. Based on discussion and observation of AM with Tyler, this therapist does not believe that RAD is a factor in his behavior. AM appears to demonstrate concern and love for Tyler, and he appears to love his parents.</p> <p>AM will bring report card next session. Recommended AM contact school about possibility of doing virtual school at the school for classes he is failing.</p>		
	TC 5 days after 33, before appt. to AM: Confirmed appt. AM states she will bring Tyler's report card and book.		
34/5 days	<p>Tyler was brought to session by his AF; no report card.</p> <p>Tyler denied making statement from last session: "I would never want to be a [father's business]". Tyler said others have told him things he did not remember, but he could not be specific about what things.</p> <p>Tyler reports he brought up some of his grades. He reports feeling supported by family and teachers. He does not appear to know how he was able to do his work and stay focused.</p>		

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	<p>TC to AM after 34 appt.: Therapist expressed concerns about Tyler forgetting his comment from previous appt. AM states she will try to monitor for other forgetfulness.</p> <p>AM reports Tyler used to have seizures, but EEG approx. 1 yr. ago showed he “grew out of them.” She states his appt. at [MH clinic #2] is in 2 days.</p>		
35/9 days	<p>AM reports Tyler will see the ARNP at [MH center #2] next month.</p> <p>AM reports she spoke to the dean about some bullying activity at lunch. She states Tyler didn’t want to go to school Mon. He told her the kids don’t want him to sit at the table at lunch. She states he is worried about getting into trouble.</p> <p>Parents report he is lying frequently. They report problems in the relationship with his sister. She tells dad, “he drives me crazy dad.”</p> <p>Discussed communication between parents and within family. Discussed family setting priorities. Discussed family stressors. Family appears to be experiencing stressors that have contributed to harmful patterns of communication, lack of time for communication and family bonding. Parents appear to have increased insight into the need to make changes. Tyler and family may benefit from sessions to improve communication and relationships. This may also help him to transfer skills to other social situations at school where he continues to experience difficulties with his peers.</p> <p>AM showed therapist a picture of Tyler and cousin to show he has a “family resemblance.”</p> <p>Family will bring family mission statement to next session. Gave communication handout again – AM couldn’t find.</p>		
	<p>TC from AM 5 days after 35: She requested we reschedule as she forgot Tyler and sister have FCAT testing.</p>		
	<p>TC with AM day of appt. 36: She states his report card says “possible retention.” Reminded AM to bring family mission statement and to contact school regarding virtual school.</p>		
	<p>TC from AM before appt. 36: She spoke with the guidance counselor’s secretary. She was told the guidance counselor was busy due to FCAT. AM explained her concerns about Tyler’s report card and that she wanted to speak to the guidance counselor about the virtual school. She reports the secretary told her the virtual school was not available at the school. AM expressed frustration that the secretary “was trying to talk me out of everything I wanted.” The secretary told AM that Tyler was not failing, “the state tells us we have to put that [possible retention] on the report</p>		

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	card.” AM states she suggested AM talk to his teachers, and she discouraged AM from doing virtual school at home.		
	TC before appt. 36 to a colleague who is a high school counselor and LMHC: Consulted regarding virtual school and AM’s rights/options. She recommended AM ask for an emergency 504 review with the Problem Solving Team (PST).		
36/6 days	<p>AM reports they have applied to another school. She reports Tyler’s report card showed unexcused absences; this should not happen as he “always had a note.” Discussed recommendation from colleague. AM will email the school to request a meeting.</p> <p>Family sand tray activity: Tyler expressed disappointment that it was a family session. Sister was excited about the activity. AM expressed it was “fun.” AF appeared to be hesitant, watchful of others and waiting for space. Discussed family’s perceptions/observations about the activity. Parents had a different perception of the instructions. Family members noted that Tyler used a lot of the space in the tray. AM noted, “he’s out there and all over, but still together in his mind.” Sand tray appears to be representative of family dynamics: Tyler absorbing much of the family’s time and energy and crossing boundaries; sister feeling unprotected and unable or unwilling to stand up for herself; sister appears afraid to “jump into activities”; father appears to take role of provider seriously, he indicates family is important to him, but he is often on the outside due to provider role; family appeared to be surprised that AM included a baby that died in her section of the sand tray.</p> <p>Discussed [family’s] process for working on the mission statement. AM stated it was “stressful.” Sister indicated Tyler was bothering her and “parents didn’t make him stop.” AM stated, “she’s old enough to speak her mind. When she does come to me, 99% of the time I do something.” Discussed consequences for bickering.</p>		
37/9 days	<p>AM reports she thinks the interview at the new school went very well. She states Tyler told the principal he really wants to go there because “I won’t have to worry about anyone picking on me”.</p> <p>Discussed parents’ observations about sand tray. AM noted that “we separate from each other... we’re not united.” Discussed other stressors and other factors affecting family’s ability to “unite” and parents’ ability to parent effectively at this time. Parents appear to have increased awareness of impact of stressors on their relationship and on ability to focus on parenting issues. Parents appear to have increased insight into different needs and perceptions of relationship. Parents appear to be having difficulty matching spoken priorities to daily activities/decisions.</p>		

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	<p>TC before appt. 38 - asked AM to have Tyler bring book to session; AM forgot appointment, but says will be there</p>
<p>38/11 days</p>	<p>AM reports Tyler’s pediatrician prescribed Focalin approx. 1 week ago because they “could not wait any longer for appt. at [MH clinic #2].” AM reports not much difference. Tyler reports he thinks he is not “annoying people too much”.</p> <p>AM expressed concern and frustration that Tyler “lies about everything.” She showed a brief video clip of an interaction between Tyler and his sister and her friend. Tyler was embarrassed that AM showed it. He stated, “that’s not me. The camera makes me sound angry, but I wasn’t. I was messing around.” Discussed with Tyler that others may have a different perception, so it was helpful for him to see this on the video. Discussed other ways to respond to the situation. Discussed reasons people lie. Tyler stated there was a “good time to lie and a bad time.” He stated a good time to lie would be about something personal like losing your house; a bad time would be when you’re being hurt. Tyler appears to lack awareness of the impact of his responses on others. He does not appear to be aware of the intensity of his emotions. Tyler appears to know there is a “lie” in his family. This needs to be addressed further. Tyler reports he lost his book. He will look for it when he gets home and call therapist when he finds it. AM states she does not know when [MH clinic #2] appt is. Therapist asked her to call while she was in the session with Tyler. Therapist asked her the date when we came out. AM stated she forgot. AM appears to continue to struggle with her forgetfulness as well; this may be a contributing factor in following up with Tyler.</p>
	<p>TC to Tyler the next day to inquire about the book. He reports he looked for his book for 15 minutes, but could not find it. He described places he had looked. He believes he must have left it at school. He states his name is in the book, but if someone found it, they “probably won’t give it back.” Therapist requested he ask at school and look again at home.</p>
	<p>TC from AM 2 days after 38: She expressed frustration that the ARNP wants to “do the same thing we’ve already done.” She wants to try the same medications, i.e., increase the Focalin or give a release type of Focalin. AM was upset that the ARNP told her she needs the adoption papers before she can prescribe medication. Therapist will consult with psychiatrist regarding medications.</p> <p>Inquired on status of 504. AM reports the school did not get back to her. She states there are only 18 days of school left, so she is not going to pursue it.</p> <p>Discussed Tyler’s missing book and the consequence for losing it. AM agreed there should be a consequence. She</p>

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	<p>reports there was a time she was “on him for everything.” Discussed having him use his money or doing chores to earn another copy of the book.</p>
	<p>TC 2 days after 38 same day to psychiatrist to consult: He recommends finding out if the dosages were maximized or stopped due to side effects. Present records that therapist has do not provide all dosages or reasons discontinued. Therapist will ask AM to obtain information.</p>
	<p>TC 2 days after 38 to AM same day: Requested she contact the neurologist for information regarding the dosage and side effects of each medication.</p>
<p>39/9 days</p>	<p>AM reports they did not watch the DVD. She states they were “busy” and she was “stressed.” AM reports Tyler has not gone to karate for the past two weeks. She expressed that he needs something for himself; he has just been “tagging along” with AM and sister. AM expressed concern about fighting between Tyler and sister.</p> <p>AM reports Tyler doing “a little better” in school. She states the guidance counselor gave him two packets to do for Language Arts and Math. She states she does not understand how, but the F on his interim went to a 100. However, she states he has an F in another class now. AM reports he worked on homework from 4:00 p.m. – 11:30 p.m., stopping 1 hr for dinner. She reports he completed only 3 papers in that time; he walked around a lot.</p> <p>AM stated the urologist said Tyler’s bladder is fine. Recommended they invest in an alarm. He prescribed medication to help. AM reports his diaper usually leaks; with the medication he still urinated, but it didn’t leak. She stated the urologist said he had a sleep disorder where he “sleeps too soundly.” However, AM stated the neurologist had done two sleep studies and said his sleep is normal. AM states Tyler goes to bed 8 – 8:30 p.m. She gets him up 2-3x during the night, and he wakes up for school at 6 am. AM states when gets him up, he is disoriented, doesn’t know where he is. AM states, “he’s starting to get rough with me” and has told her “you are getting on my nerves.” In the morning, he does not remember. AM states he says, “I wouldn’t do that.” AM states when he is awake, he does not mistreat her.</p> <p>AF expressed frustration that Tyler is “always correcting me.” Discussed priorities with parents and impact of stressors. Discussed Tyler’s behaviors, discipline/use of ACT limit setting, consequences for losing book, fighting with sister. Parents appear to be aware that their priorities do not match their activities. They appear to have increased insight into the toll stressors are taking on AM’s health and family. They also have increased awareness of</p>

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	<p>differences in discipline and that some of Tyler’s behaviors, i.e., correcting AF, may be learned behaviors. Homework: AF will track time he spends on video games; AM will look into dr. appt.; contact referral sources provided for assistance with stressor; use ACT limit setting; DVD.</p>
	<p>TC 5 days after 39 - AM had forgotten to remove appt. from her calendar after rescheduling.</p>
	<p>TC 7 days after 39 - missed appt.; AM thought it was tomorrow, but found card stating it was today</p>
<p>40/2 wks</p>	<p>AM reports follow up visit with pediatrician. Tyler reports the dr. added Kapvay at night to Focalin 10 mg Tyler stated “Focalin was the first medicine I took.” AM expressed concern that Tyler and sister were still fighting “every time they see each other.” Tyler denied fighting “all the time.” AM expressed frustration that Tyler continues to lie. She can’t tell when he is telling the truth or not. She states she has taken all electronics away, but he sneaks in to get them. She states he lies about items on his check list, and she cannot trust him to do anything she asks. AM states the papers were lost for appt. for stressor yesterday, but agency called and rescheduled for tomorrow. Session with Tyler. Discussed lies. Explored his comments about lies from last session with him. He indicated a fear of losing home and having to move....Tyler states he likes himself because” he is friendly, but others are not friendly toward him.” Discussed loss of electronics and for what amount of time. Tyler stated there is no consistency in the amount of time: “when you lose something to mom, you don’t know when you’ll get it back.” Tyler denied AM’s comment that he cannot do items on the checklist. Tyler indicated it is good to lie about feelings so others wouldn’t make fun of him. He reported he has not been to karate in a month because they were “busy” with “family stuff.” He reported they are “never home.” He indicated he enjoyed spending time with dad. Tyler’s 3 wishes: stay home for a day; more time with dad; mom stop bothering me and dad. Tyler appears to repress negative feelings so he is not vulnerable. He appears to be lacking in social skills regarding sharing information/thinking he has to lie and in interactions with peers. Tyler appears to lack awareness of social deficits. He appears to underestimate/report incidents of lying and appears to lack insight into his behaviors. He is unable to identify qualities/characteristics he likes about himself. His responses appear to indicate he is struggling in his relationship with his AM. Responses indicate there may be inconsistency in parenting/consequences.</p>

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	Homework: track items on checklist for next two weeks. Obtain book, read chapters 2 and 3. AM was given CDC to complete while therapist was in session with Tyler. Plan to score.		
	2 days later faxed release to ARNP with request she call therapist.		
	TC same day appt. 40 to AM. Requested she contact pediatrician or pharmacist for records of medication history missing from neurologist's records and bring copies of report cards next appt.		
	TC 3 days after appt. 40 later from AM. Left voice message that AF is unable to meet for scheduled appt. in 3 days.		
	TC 3 days after appt 40 to AM same day. Rescheduled appt. to day earlier with Tyler. Asked AM to have him bring his book and chart. AM states she was reminding him daily to get the chart out of the car. She states he told her he didn't have to. AM will bring medical and school records.		
41/1 wk	AM expressed several concerns: 1) Tyler cannot get along with others. AM went to give him his money at the bus stop in the morning. She stated, "he's sitting by himself on the ground with his head down. All the other kids at the bus stop are cutting up". AM asked him why he wasn't with them, he replied "they don't like me." 2) He does not defend himself; picked on at school. A student threw a pen that hit him in the cheek; the teacher saw, and student got in trouble. 3) AM expressed that she and AF "are having a hard time liking him." She states AF said "if this is how we are feeling, imagine the people at school." AM reports she is not seeing results with Kapvay. AM states she is "on edge"-- "the slightest thing gets to me. I've forgotten what it's like to be a mom. I'm strictly the disciplinarian. I go in his room to give him love and find him doing things he is not supposed to be doing." 4) AM states his cousins are coming to visit. They are really good kids -- achievers. They love Tyler and work with his issues. She is afraid Tyler will embarrass his sister in front of them at the soccer field. 5) AM worries that video games are his "only outlet," and he is "learning to exit." She states "it's just us 3." Session with Tyler. He completed the ADES. Discussed items that were notable. Tyler was avoidant when therapist tried to discuss in depth. It appears he feels guilty/shameful that he has "feelings that shouldn't be there", i.e., "anger when I should be happy; "jealous of sister". Discussed school. Tyler reports being bullied by kids. Plan to review records AM brought. Rule out dissociative symptoms.		
	ATC same day of appt. 41 to psychiatrist to consult. Left message.		

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	TC 6 days after 41 to pediatrician. Scheduled time to go over notes unable to read next day.		
	TC 7 days after 41 to pediatrician. Scheduled to speak to person in 2 days.		
	ATC 8 days after 41 to psychiatrist to consult. Left message.		
42/9 days	<p>AM reports she and a friend took the kids to the museum and a movie yesterday. She reports Tyler “was like a zombie.” She states Tyler told her it was not due to the medication as she thought. She reports he told her he didn’t “get a good sleep.” AM states he is still wetting every night, even when she wakes him up. She reports when she gets him up, he is “getting mad” and he’s “not all there.” She states they have not gotten a sleep alarm due to the cost. AM reports he has frequent nightmares. She reports he is going back to the neurologist in one month. AM reports Tyler did go to the soccer field with his cousins; she states he was fine.</p> <p>Session with parents. Reviewed treatment and history with parents. Explored sleep behaviors, i.e., nightmares, enuresis. Discussed parents’ interactions with Tyler. Explained impact of trauma history on behaviors and possibility of somatic dissociation occurring.</p> <p>Parents appear to be decreasing time spent with Tyler due to his negative behaviors. Parents appear to have increased awareness of need to have positive interactions with Tyler to maintain a positive relationship. Parents appear open to discussing his history with him.</p> <p>Plan to consult with other professionals involved in Tyler’s care, i.e., neurologist, pediatrician, [MH center 2], as well as psychiatrist colleague. Recommend AM or AF spend 30 minutes each day with Tyler in positive activity.</p> <p>Plan to schedule next appointment after consultations completed.</p>		
	TC same day as appt. 42 to pediatrician’s office. Spoke to office assistant regarding medications. Able to clarify some of the pediatrician’s notes, however, they are transferring to an electronic system so not all notes were available to her at the time of the call.		
	TC same day as appt. 42 to [MH center 2]. Medical records identified ARNP; sent email for her to contact therapist.		
	TC same day as appt. 42 to neurologist’s office. Receptionist sent him a message to call therapist.		
	TC 4 days after 42 from ARNP at neurologist office: Discussed treatment history. She concurred that symptoms of enuresis could be somatic. She recommends informing Tyler of his history.		

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	TC 4 days after 42 with psychiatrist consulting with: Discussed Tyler’s history and treatment history. Psychiatrist states it is possible that the enuresis is somatic, but difficult to prove scientifically. He states it is possible to have some dissociative symptoms due to his history.		
	Email same day to ISSTD list serve: Responses received from two professionals well-known in the field, Dr. Sandra Wieland and Na’ama Yehuda, concur with therapist that indications of dissociation are present and need to be addressed.		
	TC 5 days after 42 with ARNP [MH center 2]: She explained the reason she needed the records from AM is to prove she is the adoptive parent. She reports she suspected Tyler was adopted because the AM didn’t know the answers to questions most birth parents would know. Discussed his history and treatment history. ARNP agrees with the therapist’s diagnosis. She states Tyler “needs therapy more than anything.”		
	ATC to AM 7 days after 42 to schedule appt. Left message.		
	TC to AM 11 days after 42. She states she is very busy at the moment and will call back later.		
	TC 12 days after 42 from AM. Scheduled appt. for following week.		
43/20 days	<p>AM reports the pediatrician increased Focalin to 15 mg one week ago.; AM thinks “it is agitating him more”. She reports she wants to take off him off of Kapvay and put him on fish oil.</p> <p>AM reports Tyler has been accepted at the new school.</p> <p>AM reports the foster care workers told them Tyler “had been put into a closet” and the “grandparents were not any better than the parents.”</p> <p>Session with AM and AF. Discussed change in diagnosis and need to inform Tyler of his birth circumstances. Discussed changes in the focus of treatment. Discussed AM’s concerns about AF’s relationship with Tyler.... Focused each on their own relationship with him. Provided education on gender differences in relationships. Obtained commitment from parents to follow through with recommendations.</p> <p>AM and AF appear ready to inform Tyler of his birth circumstances in order to help him address trauma behaviors. Recommendations: AM will not change any medications without consulting the prescribing dr., 2) AM will schedule appt. at [MH center 2] to have medication prescribed by mental health specialist (psychiatrist, ARNP), 3) AM will schedule a medical appt. for herself, 4) Contact agency regarding stressor, 5) Parents will spend one-on-one time with Tyler daily, 6) AM will keep log of her daily schedule, 7) AM and AF will draft letter to son to help begin scripting</p>		

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	discussion with him. Plan to complete updated treatment plan next session. Plan to continue preparing parents to tell Tyler about his adoption circumstances.		
	TC same day as appt. 43 to consult with adoption counselor: Discussed disclosing adoption to child. She recommends when telling him his story to emphasize that “all children are entitled to safety and they are sorry it happened.” She states at this point the “issue is more about the trauma than about the adoption”. She suggests they draft a letter to get their feelings out and suggested ways to tell him, e.g., “never wanted him to feel unsafe again, wanted to make everything perfect. At the time, they thought it was best not to tell him. People thought that babies don’t remember, but the things that made you unsafe are impacting you now.” She recommends preparing the parents and processing their feelings before telling the child. She recommends the therapist and parents tell him alone, and then ask when/how he would like to tell his sister. Let him know who else knows.		
	TC 1 day after 43 with AM: She expressed concern about talking to Tyler until she knows how her health is. Therapist addressed AM’s anxiety. AM reports she is feeling overwhelmed with the requirements of the new school. She states he has science projects and has to create a blog. Encouraged AM that schedule planner will help. AM states she called the dr. re: stopping Kapvay and giving fish oil; she ok’d		
	TC day before appt. 44: AM reports parents have not written the letter. Discussed obstacles and priorities. AM states she will do it and encourage AF to do his also.		
44/1 wk	AM reports AF unable to come due to difficulties at work. She states AF did not complete his letter. AM completed homework except for contacting [agency for stressor]. She reports she is unable to get medical help at this time for herself. AM reports no medication was prescribed at [MH center 2]; next appt. there is in one month. She reports Tyler’s medication bottle fell into the sink; they may have to wait for insurance approval for refill. Requested AM have neurologist fax record showing no sleep d/o and session report at appt. in 4 days. AM states Tyler is “bombarded with homework over the summer.” She states school starts in one month. Reviewed AM’s letter. Addressed her concerns about his possible reaction to disclosure. Provided education		

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	<p>regarding the overlap of symptoms in diagnosing ADHD and symptoms caused by trauma. AM shared examples she has noticed of behaviors due to trauma. AM reports when he first came to them, “he would take his blankie and go straight to bed – no kisses – he didn’t know”. She states it was a couple years before kisses were given. AM appears to be highly concerned about the impact disclosure will have on Tyler. AM is not certain that she wants to disclose the information at this time. AM appears to understand the impact of trauma.</p> <p>Discussed blocking off time in schedule planner for priorities. Clarified AM’s understanding of role of psychiatrist. Began discussing goals/objectives for tx plan update.</p> <p>AM appears to understand the importance of setting goals/priorities and following through.</p> <p>Homework: 1) AM will contact [agency] to determine eligibility for medical appt. for herself, 2) AM will contact [agency] or other source for assistance with stressor, 3) AM will write one-on-one activity with Tyler in schedule book daily, 4) AM will log other activities; block out times for priorities; track wetting/no wetting, 5) AM will read chapter provided – case study of child with somatic dissociation.</p>		
45/1 wk	<p>Tyler reports he does not maintain eye contact when talking because he “gets distracted.” He says he “annoys others” when trying to meet them, but he could not identify what he does. He reports he spends 1 hr/day playing video games and 8 hrs/day watching t.v. He reports they have “no time” to go to the library.</p> <p>Individual session with Tyler. Discussed his concerns about not being good at “communicating” with others, sister telling him what to do, and sleep/enuresis. Tyler states when his sister “tells me I’m not doing something the right way, I go nuts.” He reports “no nightmares since age 10”; he states he was afraid of the dark then. Reviewed school grades. Discussed new school. Ungame questions:</p> <p>“Birthday present I’ll always remember” – PS3.</p> <p>“I lose track of time when” – playing video games.</p> <p>“How do you feel about competition?” – I hate it. Someone has to lose – me.</p> <p>“I can hardly wait to...” – play video games</p> <p>“I feel free to be myself when ...” – playing video games.</p> <p>Tyler reported he read the book, but states he “can’t remember anything”; he did not do the activities at the end of the chapter.</p> <p>Tyler denied needing to receive counseling at the beginning of the session, but then identified areas of concern</p>		

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	<p>throughout session. He appears to understand what some problems may be; however, he does not appear able to reflect on what behaviors contribute to the problems or how to problem solve. He does not appear able to give an accurate report of his sleep/drink schedule to determine any possible impact on nighttime enuresis. He reports he goes to bed between 8-9 p.m., falls asleep at midnight, bathroom, up 6 a.m.</p> <p>psych notes reflect video games appear to be means of escape</p> <p>AM reports appt. w/neurologist cancelled. She reports Tyler is doing “well”, but did not expound. Tyler reports he thinks the medication is helping.</p>		
	<p>TC 6 days after 45 from AM: She states they are unable to keep the appt.; AF was admitted to the hospital.</p>		
	<p>TC next day to AM: Discussed purpose of meeting with the family is to build safety in the environment. Therapist recommended AM take time to research more; offered to let her use room at the office to read information [as she doesn’t want to have adoption books in the house]. AM states Tyler is happy at this time. AM states Tyler met some kids from new school at the library. AM is hopeful this will make a difference. AM reports she is enroute. She will call to schedule.</p>		
	<p>TC 11 days after 45. Scheduled appt. for Tyler in two weeks.</p>		
	<p>TC day before appt. 46 with AM: She states he “has worked really hard over the summer and he is doing really well”; orientation yesterday. Confirmed appt.</p>		
46/27 days	<p>AM reports school will have ‘overnights’. She states they discussed enuresis with the teacher. Tyler reports he is feeling anxious about 1st day of school. He states he is concerned he will be “annoying.”</p> <p>Discussed his perception of “annoying.” Tyler was unable to identify behaviors that would be “annoying.” Discussed reading cues from others. Assessed his ability to read expressions. He played with the hospital during this discussion. Tyler then created a sand tray with vehicles in wrecks off a bridge; unable to make up a story about the sand tray. Tyler appears to be able to read expressions, but appears confused about behaviors that are annoying. He presented with anxiety, but also excitement about school.</p> <p>Homework: Ask family members what he does that is “annoying” and behaviors that they enjoy.</p>		
	<p>TC 5 days after 46 to AM: Confirmed appt. next day. Reminded AM to bring case study provided.</p>		

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47/6 days	<p>AM reports she gave the chapter to her sister to read [case study on dissociation]. She expressed that she feels Tyler has “too much happening right now to present anything new.”</p> <p>She reports the parents received a phone call from the principal yesterday, and they will meet with her, the teacher, and Tyler on Friday. She states some parents had called and students wrote letters that Tyler was poking other classmates, kicking them under the table, and talking excessively. AM states overnights are once/month. AM reports Tyler may not be able to go. AM reports Tyler told teacher he forgot his medicine, however, he told AM he took his medicine.</p> <p>AM states Tyler had his appt at [MH center 2] -- still on Focalin 10 mg and fish oil.</p> <p>AM reports Tyler is “urinating on the carpet in his sleep” but he “will swear up and down he did not do it.” She states Tyler made his own checklist of things to do to get ready, e.g., wash face, brush teeth. She states they haven’t had to tell him, and he has “no body odor. AM states this is significant because even at 8-9 months old, his head would sweat.</p> <p>Discussed points from chapter. Discussed Tyler’s behaviors and medication. Discussed his homework regarding talking to family about annoying behaviors. AM states he has not mentioned it. AM reported they handled the phone call differently. She told Tyler it was his problem to solve. She suggested he write on paper how he could solve it and hang it in his room to read over and over. AM stated he said he could try holding an eraser/ball in his hand. Asked AM when Tyler was successful. She stated when he works one-on-one. AM states she suggested he moved away, however, he said he does not want to do that – he’s done that before. AM stated Tyler is staying longer on Weds. to do work; this was his idea. AM states he is not playing video games. She states he is watching t.v. going outside instead.</p> <p>Tyler does not appear to be able to control his behaviors despite his best intentions to do well. Medication does not appear to help. AM appears concerned that introducing information at this time would be too overwhelming.</p>		

Appendix H - Emily Assessment Chart

Trauma Assessment	
physical/sexual/emotional abuse	Not known, but suspected. Adoption report stated “that Emily had numerous bruises on her head. . . .”
neglect	Adoption report: “When officials finally awoke the mother, [brother’s name] was found sleeping upright in a chair with no diaper on and dried feces on his buttocks. Emily was awake and sitting in a playpen in another room. The home was cluttered with dirty clothes and in a poor condition. The mother became hostile and used racial slurs. She appeared to be under the influence of drugs and alcohol but refused a drug test. The father complied to a drug test and was found positive for cocaine. An individual in the neighborhood stated that 3 out of 7 days the children were found outside by themselves early in the morning while the parents were sleeping inside.”
poor attachment	Adoption report: She was in 13 foster care placements from 9 months to 2 years of age.
witnessing violence	Not known with certainty, however, in adoption record it is written that the BM “stated he [BF] was never abusive to her, but that she hit him.”
loss of parent by death/separation	Removed from biological parents at 9 months old.
illness/medical procedures	Hospitalized at 2 years old for two weeks for malnutrition.
peer rejection	Siblings
Screening Instruments/Assessments	
Child Dissociative Checklist (CDC)	Score of 26

Symptom Assessment	
<p>Trance States: lapses in attention; periods of non- responsiveness; blank stare/empty eyes; daydreaming</p>	<p>1 -- CAI – doesn't stay focused 1 – SC – doesn't listen; easily distracted 2 -- SC – can't pay attention; doesn't listen; easily distracted 2 -- school - RT reported she does appear to "check out" at times TC 6 days after 2-38 with guidance counselor – zones out in class</p>
<p>Amnesia/transient forgetting: lying; forgetting recent event; forgetting trauma</p>	<p>lying/denying: 1-11 - FM discussed lying behaviors at first filial group. 1-19 - Emily had urinated on pillow of friend whose family was visiting from GA, and then tried to lie about it and blame two of her siblings. 2-1 - AM: She lies... TC two days after 2-4: Incident with blue popsicle... she lied and would not say it was hers. 2-14 - Parents report if they are away from home, there will be one night that she will misbehave on the weekend. They described an incident at the maternal aunt's house. At bedtime, she got into the bag AM left in the room. She got into the sanitizer, denied when asked, then blew up "it wasn't me; you don't like me; I hate my family; why are you being mean to me!" for approximately 20 minutes. 2-16 - Brother confronted her on lying about her intent to give him a candy; in this incident she was not lying, but she did admit that she does lie. 2-17 - They reported she lied at school and told everyone AM was having a baby. TC 10 days after 2-23 - AM reported she still attempts to be sneaky and deceitful. For example, she asked for a cookie, but she took 6 instead of 1. When AM asked her, she denied it, then said "o.k., fine. I did it, but it wasn't me." 2-38 - AM reported she still demonstrates lying behaviors. She stated her "first answer to things is a lie", i.e., "homework finished?", "eat food in your lunch box". 2-45 – AM reported Emily and sisters spent the night at grandma's. As AM was getting the suitcase together, "out falls a stack of money – 2 dollar bills". AM reports Emily lied, "I don't know why [brother] put that there." AM made her tell grandmother who told her she could not come over for a couple nights as a consequence. AM reports she didn't appear to be affected. On the way home, AM reports "Emily threw a fit in the car – 'I don't want to sit by you! I didn't do it! I didn't steal the money!'"</p>

	<p>Amnesia 1-35 – Emily showed no recollection when showed the picture of her birth parents. 2-17 - AM reported she appears to get confused when telling a story and does not always get the facts straight. 2-24 - Emily reported she doesn't remember her birthday last year, Christmas, or yesterday. She stated she remembered Thanksgiving and friends/relatives of mom's with piercings.</p>
<p>Imaginary playmates</p>	<p>TC two weeks after 2-46: She reported she asked Emily during and after a fit if it was Emily. She stated Emily told her an imaginary friend dared her to do some things. 2-47 - AM asked Emily to do a show about what happened the other night. Emily and AM played out this show. Emily's brother hit her on the head. She tipped the chair over and had a fit. Her daddy took her outside so she could calm herself down. She reported her friend, Bob, came to help. Therapist asked her to draw a picture of Bob. She reported that Bob was bald and naked. She gave various ages for Bob. It appears he may be a baby. Emily wanted to make a book. She titled it "My feles...Bob pigts" [My feelings...Bob pictures]. She initially wrote "Lizzy" before the word "My", but then colored over it. She stated that Bob dared her to do things. She stated he is there at night when she has trouble sleeping, but he does not help. 2-49 - Emily wanted to make another book about Bob as she left other one at home.</p>
<p>Identity alteration and state changes/ changes in affect and behavior: hearing voices; switches; use of third person in reference to self; regression or pro-gresssion in age; changes in ability, likes/dislikes, voice/ demeanor, emotion/ rageful behavior</p>	<p>hearing voices: 2-44 – AM stated she will look to the side as if she heard someone speak to her. switches: 1-17 - FM asked Emily to put on her leotard for gymnastics, but then remembered she wanted her to go potty. FM states she was agreeable. She went in the bathroom and closed the door; a minute later she opened it and in a completely different mood exclaimed "I'm not going potty". FM said it escalated to "I'm not going to wipe". FM says she made a mess and had to have a shower. Then she had a full out tantrum. FM gave her a bear hug and told her to put her head on her shoulder. She states it ended just as quickly. 1-29 - AM reports things have been going well – no incidents 1-30 – one week later: AM reports they have had to strip Emily's room because she is destroying everything, blinds, pictures, etc. She reports she destroyed a photo album. She had urine everywhere after her nap. AM reports they don't even hear her come out, or when she does come out at nap time, and they send her back, she swipes things along the way. She took the knobs off her dresser and they found the screws in her mouth. TC after 2-4 - We never know what Emily we're going to get. She can change in a second and it's hard to</p>

<p>Identity alteration and state changes/ changes in affect and behavior: hearing voices; switches; use of third person in reference to self; regression or pro- gression in age; changes in ability, likes/dislikes, voice/ demeanor, emotion/ rageful behavior</p>	<p>know what triggers it.</p> <p>email sent day of 2-7 before the session - AM reports several changes in behavior between trying to be helpful and having tantrums: trying to get a bottle when she heard her sister cry – she’s been off the bottle for over a year; calling when she heard her cousin get hurt at gymnastics; tantrum when told it would be time to get out of the pool; tantrum when woken up, [another tantrum] outside when told couldn’t go in yet – only swam for 2-3 minutes, after speech therapy with trigger unknown, anytime asked to do something. “Turning her feet and walking on her ankles.”</p> <p>email 4 days after 2-11 from AM - sometimes she is too out of control for my strength.</p> <p>TC morning before 2-12 - AM reported she started screaming when she gave her 10 minutes notice to finish playing. AM reported she walked on her ankles, shrunk her shoulders, and whined and groaned. She states she took the glass of water by her bed and poured it over her head, then complained about being all wet.</p> <p>2-15 - Emily was active and energetic throughout session – doing cartwheels and back bends It was difficult to direct her attention to activity. She noted the chair by the couch and asked “Is that your time out chair?” [she had seen the chair several times before]</p> <p>email five days after 2-15 from AM - Emily has become increasingly difficult...she changes from nice to mean in an instant...but is always looking for a way to be deceitful, or do something she shouldn’t...and when she is caught which is 99%...because she usually tells on herself through actions, or she’ll say something that is suspicious...It doesn’t matter our reaction. I can approach it with no intention of getting her in trouble, or I can state it as fact to her... I can stay as calm and mello [sic]...and she still freaks. The past week has been all day every day is a fight with her.</p> <p>2-17 - Discussed extremes of behavior, i.e., need for independence and then need to be babied</p> <p>2-19 - AM reported when she went to wake Emily up, she found she had defecated and wiped it all over her clothes and comforter. AM reported she giggled about it. AM reported she had her help clean up the mess, i.e., take comforter to the laundry room, etc. She states she got more defiant with each instruction. She began jumping on the bed, hitting the ceiling fan. When AM stopped that, she began emptying her drawers, tried to knock her dresser over, yelling, “I hate you”. AM reported she spanked her. She stated Emily looked at her and said “you spanked me” as if wondering why. AM told her “yes, I did, this is unacceptable behavior”. When AF came in, she got defiant again. When she was told to get ready for school, she stated, “I’m not doing it” repeatedly.</p> <p>Email two days after 2-19 to AM: She gets so angry so quickly about doing routine things... brushing her</p>
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<p>Identity alteration and state changes/ changes in affect and behavior: hearing voices; switches; use of third person in reference to self; regression or pro- gression in age; changes in ability, likes/dislikes, voice/ demeanor, emotion/ rageful behavior</p>	<p>teeth, cleaning up after self. I asked her to clean up the computer desk, where she had left a mess of DVD's, papers, crayons, etc. She screamed no, and went in her room and put a hole in her closet wall with the heel of one of her dress shoes. AF was gone last night playing softball, and she was really good until I gave her warning shower time. She hit [sister], and we ultimately ended up in her room. I wrapped her like a taco in her bed spread and just held it closed until she stopped screaming and flailing. (and I held [sister] too...I was sweating after the 45 minute meltdown!) But, I said to myself this is ridiculous. So, I stood up... and said loudly but with really no emotion "Emily your fit is over. Follow me to the bathroom, wash your face and hands. (She did). I said brush your teeth. (She did, then she put her hands under the faucet, which I thought she was going to drink the water that was pooling in her hands... nope she splashed the mirror, and counter... I didn't react, just passed her towel, and she cleaned it, but watched me.</p> <p>email same day as 2-21 from AM - She had a distinct change tonight. She actually was very good all afternoon and evening. She asked if she could start to draw. I said yes, She began to draw and then about 5 minutes into it, I asked her to clear her dinner mess because it was right where she was coloring. That made her flip. She tore her paper into shreds, flipped the kitchen garbage, and completely lost it.</p> <p>TC 13 days after 2-22 - AM reported last night it was a "huge ordeal" to go to bed. She states it happened suddenly, like snapping your fingers. Emily had her bath, put the laundry away, and AM said "let's get your meds", "let's sit down", and "boom." AM said Emily went to her room and slammed the door.... They could hear her begin to kick the wall, so they went in.</p> <p>2-23 - AM reported Emily had a meltdown at cheerleading on Tuesday. She stated the coach commented, "that wasn't Emily at practice today". AM reported Emily was "not her" for two hours.</p> <p>2-24 - She seemed upset at not being able to remember. She wanted to switch topics and activities – slap jack, Santa. Emily tried to make Santa, directing the therapist and mother to make parts of him, but had difficulty making the pieces fit – much like the pieces of her life. She abruptly stated she wanted to leave. Then she stated she was hungry.</p> <p>2-41 - Emily appeared confused at the beginning of the session. Two times she responded with a color when the question had nothing to do with a color. Emily initiated a game of "who is the nice girl". One time she asked "who is the mad girl."</p> <p>2-47 - Emily presented a puppet show about a dog named Buster meeting a friend. She incorporated the theme of another animal coming and "being mean". Another dog named Buster came to help. When asked,</p>
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<p>Identity alteration and state changes/ changes in affect and behavior: hearing voices; switches; use of third person in reference to self; regression or pro-gression in age; changes in ability, likes/dislikes, voice/ demeanor, emotion/ rageful behavior</p>	<p>she reported that there were two dogs named Buster. One dog knew about the other, but the other one did not know about this one.</p> <p>email morning after 2-48 - The next video clip was back in Emily's room.... "I'm hungry". The she is tired. Then she wants dad to hold her. He said, "I tried to hold you. You hit me and kicked me." She says, "I want a taco"....AM asks her if the sores on her tongue hurt. She says "no", then follows with "yes."</p> <p>2-49 -She stated homework is not a problem, but then said it was.</p> <p>2-51- AM reported Emily got in the car from school acting out of character, i.e., flipping in the seat, doing handstands, and repeated, "I'm not doing my homework" ten times. AM tried to let her know she wanted to tell her something. Emily asked, "Is it something fun?"</p> <p>2-52 - Emily wanted to play with the beach ball. AM commented, "It's like it's always new when she plays with it". Emily commented during play, "I'm a baby."</p> <p>third person reference:</p> <p>2-6 - Ways to cheer self continued: cleaning the books by herself; singing or listening to music; <i>telling herself to clean this room</i>; and cleaning grandmother's playroom.</p> <p>regressive behaviors:</p> <p>1-1 - FM: Emily continually puts objects and her fingers in her mouth.</p> <p>1-6 - PT: "behaviors appeared regressive today. She displayed "baby talk", emptying toys, destructive behaviors. "...due to developmental delay, Emily behaves more like a 2 year old."</p> <p>TC 3 weeks after 1-33 - AM reports Emily had eaten the electrical protector the day before.</p> <p>Email AM sent before session 2-7 - "Turning her feet and walking on her ankles."</p> <p>TC morning before 2-12 - AM reported she started screaming when she gave her 10 minutes notice to finish playing. AM reported she walked on her ankles, shrunk her shoulders, and whined and groaned.</p> <p>TC twelve days after 2-34 - She woke up crying that night for mother. She was aware the alarm on her door would go off. She told AM "my door will scream."</p> <p>2-38 - AM reports Emily paints her hands up to her arms at home too. She states she will ask permission to paint her hands, but she always takes it further. AM states she notices Emily acts younger sometimes at home and school. She states she appears to act 9 or 10 when she is cheerleading, but she notices a change in her the "second she gets in the car to go home." AM reports she becomes whiny and oppositional, i.e., to putting seat belt on, uses baby talk.</p>
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<p>Identity alteration and state changes/ changes in affect and behavior: hearing voices; switches; use of third person in reference to self; regression or pro- gression in age; changes in ability, likes/dislikes, voice/ demeanor, emotion/ rageful behavior</p>	<p>2-48 - Regressed behavior observed especially in her language, e.g., “nop it! Instead of “stop it” and use of grunts/groans.</p> <p>2-51- She reported a short time later, Emily came into the room and started walking on her ankles.</p> <p><i>urinating behaviors:</i></p> <p>1-7 - FM reports difficulty between lunch and nap time. “When I send her to room, she defecates, urinates, and tears the sheets off the bed.”</p> <p>1-10 - Over the weekend, she stripped her bed, shredded the mattress protector, and used her urine to have a tea party with her baby doll.</p> <p>1-18 - FM reports Emily was playing restaurant during their play session and urinated in the bucket with the dishes.</p> <p>1-19 - Emily had urinated on pillow of friend whose family was visiting from GA, and then tried to lie about it and blame two of her siblings.</p> <p>1-27 - AM reports Emily peed in new home.</p> <p>1-30 - She had urine everywhere after her nap.</p> <p>1-34 - Mother said “let’s go lay down.” Mother reports she had gotten up to go to the bathroom. When she returned, Emily had urinated all over the room....</p> <p>changes in likes/abilities:</p> <p>2-1 - School performance is inconsistent: One day she can read a passage; another day she looks at the same passage as if she’s never seen it – the same with math. AM reported that the resource teacher (RT) said it is difficult to test her because she is inconsistent.</p> <p>2-23 - AM discussed with teacher that Emily does spelling with mom and gets them all correct, but then gets a “0” on the test.</p> <p>2-21 - AF reported her favorite thing changes from week to week. AM reports some days she does well with homework, but other days she shreds it. Some days she dumps her backpack all over; other days she doesn’t.</p> <p>2-51 - AM reported Emily displayed different behaviors yesterday morning. She told her to get dressed, and Emily responded, “I can’t get dressed. I don’t know how. It’s going to be backwards if I put it on.” AM told her she would help her fix it if it did. AM stated she came out stomping. AM told her to get dressed again. She replied, “I’m too tired.” AM told her dad was making her eggs. She stated she didn’t like eggs. AM offered her cereal. She stated she didn’t like cereal. AM told her no more choices until she got dressed. AM stated she started getting upset, asking her repeatedly, “Is it a P.E. day? Is it</p>
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<p>Identity alteration and state changes/ changes in affect and behavior</p>	<p>a P.E. day?” AM told her “no, it’s a red shirt day.” Emily stated, “I want to wear a skirt.” AM told her to go in her drawer and get one. She replied, “I can’t. I don’t know how.”</p> <p>demeanor: TC 3 weeks after 1-35. AM reported they went to Disney World for the weekend, and “she was absolutely wonderful...little things here and there, but no meltdowns or angry words. There was a notable change in her face when it was time to go home.” 2-45 – AM reports change in Emily’s face, drastic switch in behavior from compliant to not compliant – usually with mother.</p> <p>emotions/rageful behaviors: 2-1 - She can still be destructive: she throws her dresser over, kicks walls, chews on her shirts, pulls her own hair, and blames others. email four days after 2-11 from AM -many times I need to leave the room during a fit for my own sanity, and she will purposefully do things to try to get me to come back...kick her closet door (which usually then falls to floor), slam the window blinds until they fall...now I hear the sound of her doing these things, I know what she is doing, and I know what will happen if I don’t go back in...the closet will be on the floor, there will be a hole in the wall, the dresser will be flipped (whatever she is kicking she will continue until it is broken, flipped, or whatever). email two days after 2-13 from AM - The other night I tried settling her first, but when I left her room to do the others, she started slamming her door, slamming the window blinds, and that was her first time marking up her bedroom walls with the sole of her shoe. TC 1 week after 2-46 - Emily lost it around 1:00 p.m. She was screaming “you don’t like me! You don’t like me!” repeatedly. AM tried to hold her, but it wasn’t working. AM reported she was starting to not feel well, and she knew her patience was low. AM put Emily in her room.... AM reported Emily tipped her dresser and stripped her whole closet. She reported she completely trashed her room. TC eight days after 2-47 - AM reported she is destroying everything. She shredded her bedspread.... She reported Emily is pushing her younger sisters down. She screams and hits anyone who is walking next to her.... She reported Emily got frustrated with her homework yesterday and ripped it up. email morning after 2-48 - She is in her bedroom. She bangs the wicker waste basket several times on the floor and wall. She throws all the clothes out of her dresser and off the shelf. There are two shelves (boards) on the shelf that AM reported were there because she broke them previously. She took them and threw them on the floor. She jumps in and out of her bed. She attempts to pull the curtain from the</p>
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	<p>window. This behavior goes on for approximately 7 minutes, 30 secs....Surprisingly AM asked her if she wanted a bath, and the behavior stopped abruptly!</p> <p>name: 2-39 - AM reported she is called “Lizzie” at school. She started that this year. 2-40 - Emily began writing name on chalkboard, but then looked around and stopped. 2-47 - Emily wanted to make a book. She titled it “My feles...Bob pigts” (My feelings...Bob pictures). She initially wrote “Lizzy” before the word “My”, but then colored over it. 2-49 - She reported Lizzy is her nickname at school</p> <p>hunger: 1-21 - She states Emily is not wanting to eat at school or home; 1-24 - She has increased appetite; she is always saying she is hungry even at school. 2-43 - AM reported Emily can eat 3 helpings and come back 10 minutes later saying she’s hungry.</p>
depersonalization and derealization	2-46 - She reported watching a movie called “angry ___ poop”. Emily described being scared when she had a dream there was blood on the floor and no one believed her. She named all family members as disbelieving, but “God believed me and then He died”.
somatic symptoms: stomach aches,head-aches, bodily pain, enuresis, encopresis, loss of bodily sensation, unusual tolerance for pain	2-17 - They reported she appears to be out of touch with physical pain: she does not feel pain from hot water or pain from biting her cheek. TC 12 days after 2-34 - She woke up crying that night for mother.... AM reported she was warm and said her ear hurt. AM took her to the pediatrician. She had a severe ear infection in both ears – undetectable by her unresponsiveness to pain.
posttraumatic symptoms: avoidance, numbing, intrusive thoughts and memories, nightmares, flashbacks, traumatic re-enactments,	1-2 - Emily is terrified of the toilet flushing, shower, garbage truck, and the fire alarm at school. She cries and cries after and the teacher’s aide has to hold her. 1-2 - She was hyperalert to sounds in the waiting room and the therapist’s movement and sounds in the playroom. 2-17 - Parents reported she is scared to turn on the shower, reason unknown. They reported she startles easily when someone comes around the corner. CDC -AM commented “she hears everything; she knows if [sister] is up, if mom gets a drink. She will say, “mommy you were up last night.” 2-44 - AM reported Emily appears to be on edge all the time. She is always alert to sounds. She has always

hypnagogic hallucinations	had the uncanny ability to watch something done once and to be able to do it, i.e., unfasten the safety gate, pinch buttons on car seat strap. AM reported she knows where they are going when driving if she has been that way before.
sexually reactive/offending behaviors	
self-injurious behaviors: head banging, scratching, cutting, burning, risk taking behaviors	<p>1-16 - She states Emily chews the inside of her lips and cheeks too.</p> <p>1-24 - AM concerned that she is chewing the inside of her mouth until it bleeds.</p> <p>1-28 - AM reports Emily is biting her cheek.</p> <p>2-1 - She reported she chews the inside of her mouth till it bleeds and she sucks her fingers.... pulls her own hair....</p> <p>2-38 - AM reports Emily has been pulling her hair at school, scratches herself, and slaps herself.</p> <p>TC eight days after 2-47 - She has been chewing her bottom lip since Friday. AM stated her lip looks like a canker sore and she has two holes in her tongue. AM stated when she gets mad at AM, she is biting herself.... She reported Emily has mosquito bites that won't heal because she is digging at them.</p>
Family Assessment	
<p>understanding/history of dissociation: No knowledge or understanding of as determined when introduced in therapy session 2-23.</p> <p>history of mental illness: Termination of Parental Rights received after second intake states birth mother (BM) had a “personality disorder”; birth father (BF) had a “mood disorder and personality disorder”.</p> <p>dysfunctional relational patterns: Family of origin Adoptive family – revealed over time with ongoing assessment</p> <p>family secrets: None known</p> <p>support system: Adoptive family is involved with extended family. Supportive grandparents in town.</p>	

Functioning at School

academic performance:

Intake Form 1 - will repeat Pre-K3 due to inability to stay still.

2-1 - School performance is inconsistent: One day she can read a passage; another day she looks at the same passage as if she's never seen it – the same with math. AM reported that the resource teacher (RT) said it is difficult to test her because she is inconsistent.

2-23 - AM discussed with teacher that Emily does spelling with mom and gets them all correct, but then gets a "0" on the test.

TC one day after 2-24 - RT will work on Math one day/week with her. She works with her 3 days/week. She has a 38 average in Spelling. They are going to move her back to 1st grade book..... AM reported she is at a kindergarten level developmentally for writing words and sentences.

2-38 - AM reported all academics were modified at IEP meeting. She gave consent for educational, IQ, and emotional testing. They will test her before the end of the school year.

TC six days after 2-38 - Guidance counselor reported she observed her in class for reading. She reported she played with her hair and sucked her fingers while the teacher was reading. She did not know to turn the page unless she saw other students turn their pages. She was unable to complete the worksheet about the story afterwards. The teacher gave her an alternate assignment and she was unable to complete it either.

TC two weeks after 2-49 - SP reported she administered the BASC and Conners.

TC two weeks after 2-54 - SP is going to do a second testing due to fluctuations in performance.

behavior:

1-2 - FM reported Emily is terrified of the fire alarm at school. She cries and cries after, and the teacher's aide has to hold her.

1-10 - She is destructive of paper, takes toys apart, puts some things in her mouth, but is listening well and completing tasks.

2-1 - ...steals little things from friends at school and the teacher's desk....

2-23 - The teacher told AM Emily was doing flips with 3-4 other girls on the playground. While the others kept running, Emily came to the teacher with the biggest smile on her face and said "nobody will play with me". Teacher redirected her to the slide and then asked "why don't you go play with the girls over there?" Emily acted like she hadn't played with them already, and said "o.k." AM reported she saw the RT yesterday and she said "Emily has been different all week". RT told AM that she was more easily frustrated and had higher levels of frustration. The RT told AM Emily will usually try when she puts a paper in front of her, but this week she said "I can't do it. I'm not doing it."

TC one day after 2-24 - Teacher reported to mother Emily is showing a side of herself that is more easily frustrated. She reported she

slapped herself in the face and is tugging on her hair; she shows no reaction to hurting herself.

2-30 - AM reported her class went to the nursing home yesterday. When they got back to school, AM realized she had things that didn't belong to her. She told her she needed to return the items. Emily became stubborn and resistant. AM held her. AM informed the teacher. She reported that she deteriorated in the afternoon in her ability to do school work.

2-31 - Teacher called AM last week regarding incident where Emily and another student were in the same bathroom stall.

2-32 - AM reported Emily had stolen hand sanitizer from other students two days ago; she had done this two weeks ago as well. She wrote letters of apology.

TC six days after 2-38 - Guidance counselor reports they did not want to have a functional behavior analysis done because they do not see the behaviors at school that are happening at home and it could delay the process even longer in getting help for her. She does have some stealing behaviors and zones out in class.

Medical History/ Evaluation

medical procedures:

1-8 - At two years old, she was hospitalized for two weeks due to malnutrition when the foster parents (FP) first obtained custody. She weighed 18 pounds.

medications:

TC 6 days after 1-10: Risperdal to help with sleep.

2-1: Tenex, Risperdal, Daytrana

Email before 2-7: stopped Tenex and started Intuniv

TC same day as 2-19: 10 mg Daytrana patch a.m.; 3 mg Intuniv a.m.; 3 mg Melatonin p.m.; 2 mg Risperdal p.m.

Fax 1 wk after 2-24: trial Zyprexa to see if improving sleep will improve emotional/behavioral control. Will decrease Risperdal to 1 mg hs (further tapered D/C if pt shows improvement with Risperdal [Zyprexa]) and continue Daytrana 10 mg. Will taper off Intuniv (2mg x 1 wk, 1 mg x 1 wk then D/C) as mom doesn't think it has helped.

Email 26 days after 2-24: discontinued Zyprexa and back on Risperdal 2 mg.

2-42: prescribed Buspirone.

2-43: Buspirone increased to 15 mg (5mg – 3x/day). She stated it helped the first week, but not now.

TC 1 wk after 2-46: increased Buspirone to 7.5 mg 2x/day and 10 mg at night yesterday. She states she was still up last night.

2-49: added another ½ mg of Risperdal during the day

diagnoses/comorbid conditions:

Report to psychiatrist six days after 1-10: Adjustment Disorder with Mixed Disturbance of Emotions and Conduct; R/O ADHD; R/O Bipolar Disorder

TC from AM six days after 1-10:	Reactive Attachment Disorder (RAD) by psychiatrist
Letter one week after 2-22 from psychiatrist:	ADHD and RAD
2-23 – CDC completed by therapist:	DDNOS
Fax one week after 2-24 psychiatrist:	Pt.s therapist questions whether Emily might have Dissociative D/O. Axis I: 313.89 [RAD]
TC 8 days after 2-24 AM reported:	“...psychiatrist considers dissociative symptoms to be part of RAD diagnosis.”
TC one day after 2-48 psychiatrist states:	“it does appear she is dissociating”.
Consultation 2 weeks, 4 days after 2-54:	DDNOS confirmed

medical evaluations:

1-21 – AM reports increased bedwetting. AM reports pediatrician tested for urinary tract infection two weeks ago – negative.
 1-23 - Pediatrician evaluated for bedwetting and eating problems – no medical cause.
 TC 4 weeks after 2-24: AM reported Emily had lab work yesterday [per psychiatrist] and a sugar check/urine sample at the pediatrician’s office. Pediatrician reported both were fine. Waiting for blood work results.
 2-25 - AM reported lab results came back o.k. Mo. states she is not sure why triglycerides were high, but psychiatrist was not concerned about it.

Functioning w/Peers

poor relationships with siblings:

2-1 - Psychotherapy note: Brothers don’t like to play with her because she sucks her fingers. The three girls play together, but usually [sister’s name] will end up crying because Emily takes something.
 2-43 - Psychotherapy note: picks fights – mainly with [sister’s name] – names, throws things at
 TC 8 days after 2-47 - AM reported it is affecting the other children. She reported Emily is pushing her younger sisters down. She screams and hits anyone who is walking next to her. AM reported she was trying to calm her down when her brother walked by. She screamed, and brother grabbed her hair – he was upset at how she was treating mother.
 2-51 - AM also relayed story about biological brother “throwing sister under the bus” when caught out of bed at aunt’s house to demonstrate relationship between Emily and her brother.

school:

Email morning after 2-48 - AM reports that Emily does well socially at school. She reports the kids gravitate to her.

Appendix I - Tyler Assessment Chart

Trauma Assessment	
physical/sexual/ emotional abuse	43 - AM reports the foster care workers told them Tyler “had been put into a closet” and the “grandparents were not any better than the parents.”
neglect	<p>Adoption Study: Tyler had a half-brother who was admitted to the hospital for “failure to thrive, dehydration, and malnutrition” when Tyler was 2-1/2 months old. He was diagnosed with “non-organic failure to thrive.” When Tyler was 4 months old, “the mother left the house at 3:00 a.m. with Tyler to go with her boyfriend who was reportedly under the influence of alcohol. An investigator located the mother and Tyler at a [motel]. The mother stated that she left the house with Tyler to go on a date. She thought taking Tyler with her was the sign of being a good parent. When the mother was asked when Tyler was last fed, the mother produced two bottles of curdled formula from the car seat that the baby had been in all day. The investigator noted that the diaper and car seat were saturated with urine.... She allegedly only bathed him once or twice during the week and changed him only once or twice a day.”</p> <p>33 - She reported “his birth mother was at the bar drinking; his room was the size of a closet, he would cry, and no one would come.”</p> <p>44 - AM reports when he first came to them, “he would take his blankie and go straight to bed – no kisses – he didn’t know”.</p>
poor attachment	<p>Adoption Study: “In addition to the incidence on [date], the mother allegedly did not provide needed interaction with Tyler.”</p> <p>33 - AM reports when they first got him, “he would not look into our eyes, and would not hug.”</p> <p>AM issues that may impact attachment: AM’s forgetfulness; baby in the sand tray signifying AM’s miscarriage/possible unresolved grief; changing perceptions of behaviors, e.g., accepting/rejecting.</p>
witnessing violence	Not known.

loss of parent by death/separation	Adoption Study: Removal from biological parent at 6 months old.
illness/medical procedures	CAI: tubes in ears at 1 year old; circumcision due to chronic infections at 2 years old; Adoption report: hospitalized for both procedures
peer rejection	<p>2 – kids tease him</p> <p>23 - AM reports changing Tyler's karate to more self defense due to "bullying."</p> <p>27 - AM reports he had difficulty with some of the kids socially [at camp]. Tyler stated "some kids wanted to beat him up."</p> <p>35 - AM reports she spoke to the dean about some bullying activity at lunch. She states Tyler didn't want to go to school Mon. He told her the kids don't want him to sit at the table at lunch.... They report problems in the relationship with his sister. She tells dad, "he drives me crazy dad."</p> <p>37 - AM reports she thinks the interview at the new school went very well. She states Tyler told the principal he really wants to go there because "I won't have to worry about anyone picking on me".</p> <p>40 - Tyler states he likes himself because" he is friendly, but others are not friendly toward him."</p> <p>41 - AM expressed several concerns: 1) Tyler cannot get along with others. AM went to give him his money at the bus stop in the morning. She stated, "he's sitting by himself on the ground with his head down. All the other kids at the bus stop are cutting up". AM asked him why he wasn't with them, he replied "they don't like me."... Tyler reports being bullied by kids.</p>

Screening Instruments/Assessments	
Conners Scales	<p>Teacher Reports: Scores from three teachers' results were clinically significant for the following Conners 3-T Scales: Inattention, Hyperactivity/Impulsivity, Learning Problems/Executive Functioning, Executive Functioning, Aggression, and Peer Relations. Scores were also clinically significant for the DSM-IV-TR Symptom Scales: ADHD Inattentive, ADHD Hyperactive-Impulsive, ADHD Combined, Conduct Disorder, and Oppositional Defiant Disorder (ODD). Teacher scores indicated follow-up was needed for Anxiety and Depression.</p> <p>Parent Report: Scores from Tyler's AM were clinically significant for the Conners 3-P Scales: Inattention, Hyperactivity/Impulsivity, Executive Functioning, Aggression, and Peer Relations. Scores were also clinically significant for the following DSM-IV-TR Symptom Scales: ADHD inattentive, ADHD Hyperactive-Impulsive, ADHD Combined, Conduct Disorder, and ODD. Follow-up was also indicated for Anxiety and Depression.</p> <p>Self-Report: Tyler's results for the Conners 3-SR Scales were clinically significant for Hyperactivity/Impulsivity and Aggression. The DSM-IV-TR Symptom Scales scores were clinically significant for ADHD Hyperactive/Impulsive, Conduct Disorder, and ODD. Follow-up was indicated only for Anxiety.</p>
Child Dissociative Checklist	<p>mother (13): 1 – 2, 3, 7, 2 -- 5, 6, 8, 9, 17 father (15): 1 – 4, 7, 8, 9, 16, 2 – 1, 2, 3, 6, 11</p> <p>Notes: “lacks awareness of injuries. He broke his wrist and didn't complain.” “No big deal about anything”. Had an ear ache as a child; his ear drum burst and “he never said till the end.” [that ear hurt]</p>
Adolescent Dissociative Experiences Scale	<p>Score is a 1 < cut-off score of 4. However, there were 4 responses that may be significant:</p> <ol style="list-style-type: none"> 1. I get so wrapped up in watching TV, reading, or playing a video game that I don't have any idea what's going on around me. (7) 4. I can do something really well one time and then I can't do it at all another time. (5 - can't remember what was taught – math/reading) 10. When I am somewhere that I don't want to be, I can go away in my mind. (7 - reports does this 2-3x/day when annoyed/angry/bored) 18. I can't figure out if things really happened or if I only dreamed or thought about them. (circled a 5 – when asked stated “I forgot to cross it out and put a 0”)

Symptom Assessment	
<p>Trance States: lapses in attention; periods of non-responsiveness; blank stare/empty eyes; daydreaming</p>	<p>Conners Scales – inattentiveness School Conference after 24 - She [Critical Thinking teacher] states he has trouble thinking and writing through. He will roll his eyes, but is not verbally rude. She reports an issue with reading his book. She reports he zones out and doesn't follow instructions. She [Language Arts teacher] states if he only has to be told to "stay focused" one time, he gets a gold ticket or candy. 26 - She states one teacher has said he is "tuning out." 31 - AM reports Tyler got one A , Bs and Cs on report card. She states he is not focusing at school.</p>
<p>Amnesia and transient forgetting: lying; forgetting recent event; forgetting trauma</p> <p>Amnesia and transient forgetting: lying; forgetting recent event; forgetting trauma</p>	<p>Lying/Denying 6 - AM states teacher reported Tyler was aggravating another student and starting to show anger. He was moving a girl's folder. She asked him to stop, but he didn't. The teacher intervened. He denied doing it. The teacher told him "I saw you." 19 - She [AM] reports Tyler lied about amount of time he played video game; consequence was no electronics for 3 days. AM expressed concern about Tyler's hygiene. She states he told her he "forgot" to wash his hair, but she doesn't believe him. TC 1 day after 22 - AM reports "I'm done". She states "he lies all the time." AM states Tyler lies about not having homework when he didn't write it all down. She states he doesn't always have enough time to write it off the board. AM states "he will wad up paper in front of me, and say he doesn't have it." AM reports his teacher wrote a note saying she knew he did a paper in class, but he didn't turn it in. AM reports teachers have not said anything about Tyler being disrespectful in class. She states they know he has ADHD and appear to give him some leeway. AM reports he lied about downloading pictures on his cell phone. 5 days after 22 - Therapist discussed with mother "lying" by not telling Tyler about his birth circumstances and risks of telling. 24 - AM reports she received a TC that Tyler had disrupted the class and had upset a female student. She states he lied about it. 27 - She states he "is not doing work, lying, won't listen, does his own thing, doesn't care." 38 - AM expressed concern and frustration that Tyler "lies about everything." She showed a brief video clip of an interaction between Tyler and his sister and her friend. Tyler was embarrassed that AM showed it. He stated, "that's not me. The camera makes me sound angry, but I wasn't. I was messing around."</p>

	<p>40 - AM expressed frustration that Tyler continues to lie. She can't tell when he is telling the truth or not. She states she has taken all electronics away, but he sneaks in to get them. She states he lies about items on his check list, and she cannot trust him to do anything she asks.</p> <p>47 - AM reports Tyler is "urinating on the carpet in his sleep" but he "will swear up and down he did not do it."</p> <p>Amnesia</p> <p>15 days after 19 - AM reports Tyler is doing well with school so far. She reports they have to "keep on him for everything."</p> <p>21 - AM reports he doesn't follow through with homework or back pack.</p> <p>22 - AM states Tyler always forgets something on his hygiene list.</p> <p>32 - Discussed academic progress and impact on future. Tyler expressed the thought that he could do a [business like his dad does].</p> <p>34 - Tyler denied making statement from last session: "I would never want to be a [father's business]". Tyler said others have told him things he did not remember, but he could not be specific about what things.</p> <p>39 - AM states when gets him up, he is disoriented, doesn't know where he is. AM states, "he's starting to get rough with me" and has told her "you are getting on my nerves." In the morning, he does not remember. AM states he says, "I wouldn't do that." AM states when he is awake, he does not mistreat her.</p>
<p>Imaginary playmates</p>	
<p>Identity alteration and state changes/ changes in affect and behavior: hearing voices; switches; use of third person in reference to self; regression or progression in age;</p>	<p>Alters/switching</p> <p>TC before 9 - The teachers expressed they don't believe Tyler wants to misbehave; he cannot control impulses. They report he really wants to belong. They suggest he get involved in a group at middle school <i>where he can have an identity</i> and sense of belonging.</p> <p>12 - The mother reports "major improvement" noticed by family and friends: more patience, haven't seen temper since school got out, listening and focusing more, considering others' feelings, opening doors for others, not wetting bed (4 days/ gets him up at 1:30 a.m.), not lying. She stated that "even last summer, he was not this good, so it's not just because school is out."</p>

<p>changes in ability, likes/dislikes, voice/demeanor, emotion/rageful behavior</p>	<p>Regressed behaviors: CAI – sleeps in fetal position. 10 – argued with a 6 year old. 13 - She [AM] states Tyler gets angry with his sister easily; doesn't act 11. 21 - AM reports she feels Tyler is being “lazy.” All he wants to do is play hot wheels and videos.... Tyler reported he goes to bed at 6 or 7. 26 - AM reports Tyler took legos to school...</p> <p>Emotions/behaviors: 6 - AM states teacher reported Tyler was aggravating another student and starting to show anger. He was moving a girl's folder. She asked him to stop, but he didn't. The teacher intervened. He denied doing it. The teacher told him “I saw you.” 8 - AM states “it is difficult to get him to focus and think when he is angry.” TC 6 days after 22 - AM reports she received an email from Tyler's critical thinking teacher and a TC from his band teacher. She states they report he was “making gay slurs; almost got in a fight, throwing things.” AM reports Tyler told her he “can't control his emotions” – states he “looked ready to cry” when he said it. TC 8 days after 27 - She states Tyler is staying after school on T/TH for 1 hour for tutoring/to complete homework. AM states Tyler was angry about doing it. He was crying at dinner “I know why you're doing this – so you can get rid of me!” 28 - Tyler raised his voice when AM's perception re: time to write homework differed from his. Tyler states raising his voice is “the only thing that shuts up my boys” at school. He appears to have insight that it is a learned behavior. AM reported something happened Sunday: AF left, but he came back. He made a commitment to stop raising his voice. 41 - He completed the ADES. Discussed items that were notable. Tyler was avoidant when therapist tried to discuss in depth. It appears he feels guilty/shameful that he has “feelings that shouldn't be there”, i.e., “anger when I should be happy; “jealous of sister”.</p>
<p>depersonalization and derealization</p>	<p>2 - Tyler reports he is the “smartest in his class”. 3 - Tyler did not appear to be aware of physiological changes when he gets angry. TC 1 week after 3, later that day – AM expressed concern that Tyler “gets up at night, pees on the carpet and the wall.” She reports he did it last night and 2 other times in last 2 months. AM doesn't believe he does</p>

	<p>it on purpose.</p> <p>TC before 9 - AM reports enuresis on carpet in room when he gets up; AM wakes him at 12:30 a.m. & 3:00 a.m. to go to the bathroom; he gets up at 6:00 a.m. up for school.</p> <p>13 - Tyler's perception of his anger is a 3; his sister's perception of his anger is a 7.</p> <p>20 - AM and Tyler completed a social skills checklist. Tyler appears to be unaware of his negative social behaviors and other's perceptions.</p>
<p>somatic symptoms: stomach aches, headaches, bodily pain, enuresis, encopresis, loss of bodily sensation, unusual tolerance for pain</p>	<p>Enuresis:</p> <p>CAI - sleeps in fetal position; still tosses and turns at night; AM wakes him up 3x/night to try to prevent bed wetting.</p> <p>TC 1 week after 3, later that day – AM expressed concern that Tyler “gets up at night, pees on the carpet and the wall.” She reports he did it last night and 2 other times in last 2 months. AM doesn't believe he does it on purpose.</p> <p>TC before 9 - AM reports enuresis on carpet in room when he gets up; 12:30 & 3:00 a.m. → bathroom; 6:00 a.m. up for school.</p> <p>39 - AM stated the urologist said Tyler's bladder is fine. Recommended they invest in an alarm. He prescribed medication to help. AM reports his diaper usually leaks; with the medication he still urinated, but it didn't leak. She stated the urologist said he had a sleep disorder where he “sleeps too soundly.” However, AM stated the neurologist had done two sleep studies and said his sleep is normal. AM states Tyler goes to bed 8 – 8:30 p.m. She gets him up 2-3x during the night, and he wakes up for school at 6 am. AM states when gets him up, he is disoriented, doesn't know where he is. AM states, “he's starting to get rough with me” and has told her “you are getting on my nerves.” In the morning, he does not remember. AM states he says, “I wouldn't do that.” AM states when he is awake, he does not mistreat her.</p> <p>42 - AM states he is still wetting every night, even when she wakes him up. She reports when she gets him up, he is “getting mad” and he's “not all there.”</p> <p>Bodily sensation:</p> <p>Child Dissociative Checklist - “lacks awareness of injuries. He broke his wrist and didn't complain.” “No big deal about anything”.</p> <p>Had an ear ache as a child; his ear drum burst and “he never said till the end.” [that ear hurt]</p> <p>1 - Tyler also has problems with constipation.</p>

<p>somatic symptoms: stomach aches, headaches, bodily pain, enuresis, encopresis, loss of bodily sensation, unusual tolerance for pain</p>	<p>3 - The mother reports stomachaches every morning for about a month. 4 - AM expressed concern that Tyler is not feeling well almost daily, even on weekends. 21 - AM reports Tyler was sick for the past week. They took him to the ER for upper gastro pain spasms. Dr. could not tell what it was; may have been a virus. 28 - "I'm sick and my back is burning." TC 18 days after 32 - AM states Tyler has had a "skin burning" sensation on and off medication.</p>
<p>posttraumatic symptoms: avoidance, numbing, intrusive thoughts and memories, nightmares, flashbacks, traumatic re-enactments, hypnagogic hallucinations</p>	<p>Symptoms Checklist – nightmares traumatic re-enactment – night time enuresis</p>
<p>sexually reactive/offending behaviors</p>	
<p>self-injurious behaviors: head banging, scratching, cutting, burning, risk taking behaviors</p>	<p>medication compliance inconsistency in following through with consequences differences in parenting styles</p>

Family Assessment

understanding/family hx of dissociation:

Ongoing assessment revealed no prior knowledge.

history of mental illness:

Adoption Study - Birth mother: “upper mildly retarded range of intelligence....She had a functional mental age of 11.0 years.” Birth father: “low average intellectual functioning and may suffer from some emotional conflict related to parental abandonment as a child.”

possible mental health issues:

Adoptive Mother (AM) memory problems:

TC 5 days after 5- AM forgot appointment.

6 - Therapist discussed mother’s memory problems.

TC 13 days after 11 - AM forgot appointment

TC 15 days after 11 - AM Forgot appointment; recommended AM rule out medical cause for memory problems as she expressed she “never used to be this way.”

TC 6 days after 12 - AM states family was at office at 6 p.m. – appt. was at 6:30; rescheduled.

TC 15 days after 19 - She “could not remember whether appt. was today or tomorrow.”.... AM reports she lost her calendar when she was sick and doesn’t remember when the school open house is. Therapist encouraged AM to rule out medical cause for poor memory.

3 weeks after 19 - AM, Tyler, and sister arrived 30 minutes late for appt. Therapist recommended AM schedule medical appt. for herself.

TC 6 days after 25 - AM forgot appointment.

TC 19 days after 25 - AM forgot appointment.

26 - She reports she lost the paper to get on to the parent portal and she is embarrassed to call the school again.

TC 6 days after 30 - AM forgot appointment.

TC 7 days after 31 - AM called to see if appt. was next day – not for 4 more days

32 - AM reports she forgot to bring the report card.

TC before 38 - AM forgot appointment, but says will be there.

38 - AM states she does not know when [MH clinic #2] appt is. Therapist asked her to call while she was in the session with Tyler. Therapist asked her the date when we came out. AM stated she forgot [to call].

TC 7 days after 39 - missed appt.; AM thought it was tomorrow, but found card stating it was today.

40 - AM states the papers were lost for appt. for stressor yesterday, but agency called and rescheduled for tomorrow.

AM possible unresolved grief:

Session 36 - family appeared to be surprised that AM included a baby that died in her section of the sand tray.

dysfunctional relational patterns:

marital issues:

CAI – AM indicated that children may have heard “raised voices.” She reported they have been married 15 year “and going strong”, yet later sessions indicated marital problems.

28 - Adoptive Father (AF) left, but he came back. He made a commitment to stop raising his voice.

AM “babies” him:

8 - AM uses baby talk, e.g., “wakey, wakey”.

23 - She reports she rubs Tyler’s back in middle of the night when he can’t sleep.

26 - AM reports his bedtime is 8 p.m.; [younger] sister’s bedtime is 9 p.m.

changing parental perceptions about behavior:

TC 1 week after 3, later that day – AM expressed concern that Tyler “gets up at night, pees on the carpet and the wall.” She reports he did it last night and 2 other times in last 2 months. AM doesn’t believe he does it on purpose.

14 - AM expressed that he had improved.

18 - AM reports some improvement in impulsive behaviors such as interrupting. She reports fighting with sister decreased.

19 - AM reports behaviors are better at home, but she is concerned about the school environment. She reports Tyler lied about amount of time he played video game; consequence was no electronics for 3 days. AM expressed concern about Tyler’s hygiene.

She states he told her he “forgot” to wash his hair, but she doesn’t believe him.

TC 15 days after 19 - AM reports Tyler is doing well with school so far. She reports they have to “keep on him for everything.”

20 - AM reports Tyler has improved on behaviors noted in initial treatment plan, i.e., demanding behaviors, interrupting, and not waiting. She reports he does still do them; “he is impatient. She says she doesn’t have to stay on him like she used to.

21 - AM reports she feels Tyler is being “lazy.” All he wants to do is play hot wheels and videos.... Tyler reported he goes to bed at 6 or 7.

TC 1 day after 22 - AM reports “I’m done”. She states “he lies all the time.”

25 - AM reports she “is not giving up.”

27 - AM reports “he has given up.” She states he “is not doing work, lying, won’t listen, does his own thing, doesn’t care.” AM states

dad took him for a “talk in the closet – 1 pop – talk some more.” AM reports they “took away his birthday.” She states they told him “you are not contributing to the family; it’s not all about you.” AM states at school he “totally ignores his teacher when she is talking and reads his book.” AM states nothing is working. She wanted to use “shock therapy” – taking away everything, spanking, thought of telling him he was adopted. AM also states she believes Tyler “wants to do good, to love and be loved”.

32 - AM appears to believe behavior is intentional.

36 - AM noted, “he’s out there and all over, but still together in his mind.”

37 - Discussed parents’ observations about sand tray. AM noted that “we separate from each other... we’re not united.”

39 - Discussed Tyler’s behaviors, discipline/use of ACT limit setting, consequences for losing book, fighting with sister. Parents appear to be aware that their priorities do not match their activities. They appear to have increased insight into the toll stressors are taking on AM’s health and family. They also have increased awareness of differences in discipline and that some of Tyler’s behaviors, i.e., correcting AF, may be learned behaviors.

41 - AM expressed that she and AF “are having a hard time liking him.” She states AF said if this is how they are feeling, “imagine the people at school.” AM states she is “on edge”-- “the slightest thing gets to me. I’ve forgotten what it’s like to be a mom. I’m strictly the disciplinarian. I go in his room to give him love and find him doing things he is not supposed to be doing.”

parenting issues:

4 - Parents appear aware of differences in expectations, need for consistency, and need to learn other behavioral and discipline strategies. Recommend social activity and increase positive interaction time with each parent.

16 - AM reports they have not had time to follow up on Tyler’s progress with making the bed. She states they “want to do the checklist, but they are always on the go.” AM states they “need help with rewards that don’t involve parents’ time all the time.”

21 - Tyler reported he goes to bed at 6 or 7

22 - AM states she is not allowing video games until Tyler brings home a report card with As, Bs, and one C. She reports he brings home papers with 0s. His interim did not have good grades. AM realized this strategy is not working.

23 - AM reports she feels like she is “doing it by myself” as she and father have different parenting styles.

24 - AM reports “father took to closet” [spanked him].

26 - AM reports they have removed all privileges, i.e., no t.v., IPOD, toys; cell phone only for school to let AM know he is on/off the bus. AM reports his bedtime is 8 p.m.; sister’s bedtime is 9 p.m.

27 - AM states dad took him for a “talk in the closet – 1 pop – talk some more.”

28 - Adoptive Father (AF) left, but he came back. He made a commitment to stop raising his voice.

40 - Tyler stated there is no consistency in the amount of time: “when you lose something to mom, you don’t know when you’ll get it back.”

47 - AM reports she gave the chapter to her sister to read [case study on dissociation]. She expressed that she feels Tyler has “too much happening right now to present anything new.”

family secrets:

CAI: Tyler does not know he was adopted. All extended family knows except sister.

35 - AM showed therapist a picture of Tyler and cousin to show he has a “family resemblance.”

support system:

CAI: Tyler’s support system mainly his AM, but also AF and an aunt and uncle.

Functioning at school

academic performance:

1st and 2nd grade – All A’s

3rd grade: B,C,A,A,A,B

4th grade: B,C,A,A, B, A

5th grade – no record of final grades

– 3rd qtr: B,C,A,C,B,B

6th grade – no record of final grades

– 3rd qtr: F,C,C,B,F,B,C,C

“possible retention”

– 2nd grade also G for completes homework assignments

- sporadic for study habits/personal development – range S,E,G

- Es and Gs for study habits/personal development in grades 1 and 2, gradually decreasing to Gs and Ss, and then to Ns and Ss in fifth grade.

31 - AM reports Tyler got one A, Bs and Cs on report card. She states he is not focusing at school. TC before 32 to AM: Confirmed appt.; requested AM bring copy of report card; discussed book for Tyler. She expressed concern that Tyler is failing. She reports he is not doing the work in class; he will do the work at home and not turn it in; he does not bring home the papers he is supposed to do; he “will lie” about not having work, about teachers not letting him come in to complete it early.

behavior:

1 - touching, aggravating other students, cursing.

TC 6 days after appt/day before session 3:AM reported she had to go out of town the week of FCAT; Tyler was in trouble everyday and had silent lunch for the week.

- 5 - Tyler reports he got in trouble at school: he told another student to “shut up” and used other “inappropriate” language (on behavioral reflection form teacher wrote).
- 6 - AM states teacher reported Tyler was aggravating another student and starting to show anger. He was moving a girl’s folder. She asked him to stop, but he didn’t. The teacher intervened.
- 7 - Tyler reports he got in trouble at school today in 2 classes and got all privileges removed at home. He reports he was suspended 3x in the past.
- TC 15 days after 19 - AM reports Tyler is doing well with school so far. She reports they have to “keep on him for everything.” AM states she goes through his backpack after school every day and it is a mess.
- TC 6 days after 22 - AM reports she received an email from Tyler’s critical thinking teacher and a TC from his band teacher. She states they report he was “making gay slurs; almost got in a fight, throwing things.
- TC same day, after 23 - The guidance counselor reports Tyler’s has had the following disciplinary actions:
 23 days ago: tardy –warning
 17 days ago: The dean spoke to him about horseplay on bus.
 10 days ago: The band teacher to spoke to his parent to inform her he is becoming a “daily disruption.”
 8 days ago: Tyler was pulling rubber stoppers out of the frame and throwing them across the room at a student.
 3 days ago: Tyler was making mean remarks and staring a student down during a nurse presentation.
- 24 - AM reports she received a TC that Tyler had disrupted the class and had upset a female student.
- 25 - She states he got ISS (In School Suspension). Clt. reports the school has a “no touch policy”. He was “goofing with his friend and ‘play punched’ him.”
- 26 - AM states she has gotten several telephone calls and emails from Tyler’s teachers. She states one teacher has said he is “tuning out.” AM reports Tyler took legos to school which the teacher took, and AM refused to get back for him.
- 27 - Tyler said he got a referral on Friday for not having his i.d.; he’s gone through 20 i.d.s.
- 28 - Tyler reports he has been getting good comments in his agenda: “good day”; “did work”; “paid attention.
- 29 - AM reports she has not seen Tyler’s agenda this week. She states, however, that he has been doing better.
- 31 - AM reports Tyler got one A, Bs and Cs on report card. She states he is not focusing at school.
- 47 - She reports the parents received a phone call from the principal yesterday, and they will meet with her, the teacher, and Tyler on Friday. She states some parents had called and students wrote letters that Tyler was poking other classmates, kicking them under the table, and talking excessively.

Medical History/Evaluation

medical procedures:

CAI: Tubes in ears at 1 year old; circumcision due to chronic infections at 2 yrs. old

medications:

Medications from age 6 years and continued to age 12 included: Adderall, Straterra, Tryleptal, Focalin, Vyvanse, Concerta, Intuniv, Abilify, Geodon, Kapvay, Wellbutrin, Clonidine, and Zantac. DDAVP for bedwetting.

medication issues:

TC 1 week after 3- AM reports they had appt. at [MH center 1], but do not plan to pursue as they do not want him on medication.

4 - Mother reiterated they do not want Tyler on medication due to concern about physical harm to his body.

16 - She states they have decided no matter what happens, they do not want Tyler on medication.

22 - Discussed with AM that Tyler may need medication if behavior strategies are not working.

6 days after 22 - AM expressed fear about medication due to experience with previous prescription affecting his liver.

26 - AM expressed she is still leery of medications.

27 - She has accepted that he may need medication.

29 - AM questions the need for medication as Tyler appears to be improving. She appears to understand that even though he is improving, he is still not functioning at a level similar to his peers.

TC before 32 - [MH center 1] prescribed Clonidine .1 mg (1/2 a.m. and 1/2 p.m.). AM reports she thinks it is the one that worked before after 1-1/2 weeks, but it does not appear to be working now.

TC 18 days after 32 - AM states the medication is not working. AM states Tyler has had a “skin burning” sensation on and off medication.

TC 18 days after 32 from AM after appt. at [MH center 1]. She expressed disappointment and frustration with dr. She reports they left with “no new prescription, no appointment, nothing”. She states the dr. said she did not know what to do because she didn’t have the previous records; AM states she signed a release for the neurologist when she was there one month ago. AM states the dr. said she needed blood work; AM states she told her they did that the last time they were there. AM expressed the dr. asked AM what she wanted her to do. AM states she will need to get a different dr.

33 - AM reports she is trying to get appt. at [MH center 2]. AM expressed concern that Tyler was not on medication; however, she stated she did not notice a difference with it. Tyler’s math teacher said he wasn’t agitating classmates like he was, but academically there was no difference.

35 - AM reports Tyler will see the ARNP at [MH center #2] next month.

38 - AM reports Tyler's pediatrician prescribed Focalin approx. 1 week ago because they "could not wait any longer for appt. at [MH clinic #2]." AM reports not much difference. Tyler reports he thinks he is not "annoying people too much". TC from AM 2 days after 38 - She expressed frustration that the ARNP wants to "do the same thing we've already done." She wants to try the same medications, i.e., increase the Focalin or give a release type of Focalin. AM was upset that the ARNP told her she needs the adoption papers before she can prescribe medication. Therapist will consult with psychiatrist regarding medications. TC 2 days after 38 same day to psychiatrist to consult - He recommends finding out if the dosages were maximized or stopped due to side effects. Present records that therapist has do not provide all dosages or reasons discontinued. Therapist will ask AM to obtain information.

40 - AM reports follow up visit with pediatrician. Tyler reports the dr. added Kapvay at night to Focalin 10 mg.

41 - AM reports she is not seeing results with Kapvay.

diagnoses/comorbid conditions:

ADHD/Mood Disorder/ODD/Nocturnal Enuresis/constipation "whole life"/possible RAD

Comments repeatedly seen in medical records at majority of appointments with neurologist: "No signs of hyperactivity, impulsivity of lack of attention span."

33 - Ruled out RAD

medical evaluation:

No neurological disorders; no medical basis for enuresis or other behavior

Functioning with peers

CAI - AM expressed concern about Tyler's relationship with his sister.

2 - ...he had some problems at school, i.e., kids tease him....

5 - Tyler reports he got in trouble at school: he told another student to "shut up" and used other "inappropriate" language (on behavioral reflection form teacher wrote).

TC 15 days after 19 - She states he is starting to complain about some of the kids.

20 - Tyler reports middle school is "funner" but "harder" too. He states he has 3 mean teachers. He eats lunch with two other boys.

23 - AM reports changing Tyler's karate to more self defense due to "bullying."

School Conference after 24 - The P.E. coach stated he has only had Tyler for a couple weeks. He states he struggles socially. He is usually reading in locker room - 60-70 kids there. He received an email that he is having issues with another child. Another teacher stated at lunch he has his hands on other students; provoking other students. He is respectful of the teacher though. His

Critical Thinking teacher reports he is a “loner” – no problems with others around him....She [Language Arts teacher] reports he has had problems with another boy since 2nd week school....The Band teacher reports Tyler got along well with 2 others in the class.

27 - AM reports he had difficulty with some of the kids socially [at camp]. Tyler stated “some kids wanted to beat him up.”

Appendix J – Child Dissociative Checklist

Child Dissociative Checklist (CDC), Version 3

Frank W. Putnam, MD

Date: _____ Age: _____ Sex: M F Identification: _____

Below is a list of behaviors that describe children. For each item that describes your child NOW or WITHIN THE PAST 12 MONTHS, please circle 2 if the item is VERY TRUE of your child. Circle 1 if the item is SOMETIMES TRUE of your child. If the item is NOT TRUE of your child, circle 0.

- 0 1 2 1. Child does not remember or denies traumatic or painful experiences that are known to have occurred.
- 0 1 2 2. Child goes into a daze or trance-like state at times or often appears “spaced out.” Teachers may report that he or she “daydreams” frequently in school.
- 0 1 2 3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive.
- 0 1 2 4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget names of friends, teachers or other important people, loses possessions or gets easily lost.
- 0 1 2 5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.
- 0 1 2 6. Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, athletic abilities, e.g., changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.
- 0 1 2 7. Child shows rapid regressions in age-level behavior, e.g., a twelve-year-old starts to use baby-talk sucks thumb or draws like a four-year old.
- 0 1 2 8. Child has a difficult time learning from experience, e.g. explanations, normal discipline or punishment do not change his or her behavior.

- 0 1 2 9. Child continues to lie or deny misbehavior even when the evidence is obvious.
- 0 1 2 10. Child refers to himself or herself in the third person (e.g. as she or her) when talking about self, or at times **insists** on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.
- 0 1 2 11. Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.
- 0 1 2 12. Child is unusually sexually precocious and may attempt age-inappropriate sexual behavior with other children or adults.
- 0 1 2 13. Child suffers from unexplained injuries or may even deliberately injure Self at times.
- 0 1 2 14. Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come from “imaginary companions” or sound like the voices of parents, friends or teachers.
- 0 1 2 15. Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.
- 0 1 2 16. Child has intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes.
- 0 1 2 17. Child sleepwalks frequently.
- 0 1 2 18. Child has unusual nighttime experiences, e.g., may report seeing “ghosts” or that things happen at night that he or she can’t account for (e.g. broken toys, unexplained injuries).
- 0 1 2 19. Child frequently talks to him or herself, may use a different voice or argue with self at times.
- 0 1 2 20. Child has two or more distinct and separate personalities that take control over the child’s behavior.

9. I hear voices in my head that are not mine.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

10. When I am somewhere that I don't want to be, I can go away in my mind.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

11. I am so good at lying and acting that I believe it myself.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

12. I catch myself "waking up" in the middle of doing something.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

13. I don't recognize myself in the mirror.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

14. I find myself going somewhere or doing something and I don't know why.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

15. I find myself someplace and I don't remember how I got there.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

16. I have thoughts that don't really seem to belong to me.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

17. I find that I can make physical pain go away.

0 1 2 3 4 5 6 7 8 9 10
(never) (always)

Appendix L – Tyler’s Medical History Summary

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
Start at 5 years old			stopped Adderall begin Strattera		anger outbursts, unhappy	
5 months			no new meds		mom took off meds	
7 months		Mood Disorder	Trileptal		no meds at this time; mom said none working; anger outbursts, impulsive, aggressive	
2 weeks			Strattera sample pack		stopped meds; made too sedated; very hyper/aggressive	
2 months	sx of ADHD inattentive; no evidence of hyperactivity, impulsivity, or lack of attention span	ADHD inattentive	none	N/A	difficulty at school staying on task, staying focused, touchy with other children; not hyperactive, impulsive, or defiant; does well socially; nocturnal enuresis	Blood work. Connors for mom and teacher. Sleep deprived EEG. Info. on ADHD and meds. F/U [1-1/2 months].

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
3 weeks			none		physical; mom reports saw another doctor	
1 month	missing page 1	missing	Focalin 5mg XR qam	N/A	missing	Discussed EEG. Start Focalin. F/U in 2 weeks.
2 weeks	mild degree of hyperactivity, impulsivity, lack of attention span	ADHD combined; ODD	Focalin 5mg XR qam	none except for occasionally difficulty initiating sleep and nightmares	improved behavior, but mo. states med. wears off early → inc. hyperactivity and impulsivity; nocturnal enuresis	Continue Focalin. Increase to 10 mg if receive complaints from school. F/U in 2 months.
3 months	no evidence of hyperactivity, impulsivity, or lack of attention span	ADHD combined; ODD	Focalin 5mg XR qam	none except for dec. appetite	mo. forgot report card – 2 As and rest Bs. 2 checks for following directions and not listening. Sporadic complaints re: behavior from school. Mom increased med. to 10 mg, led to increased talkativeness, so decreased back to 5 mg. Occasional difficulty initiating sleep. Nocturnal enuresis	Continue Focalin. F/U in [3 months]. With copy of second report card.
4 months	no evidence of hyperactivity, impulsivity, or lack of attention span; no f/u on contacting	ADHD combined; ODD	Focalin 5mg XR qam	none	well academically; mildly aggressive, disturbs others in class; nocturnal enuresis	Continue dose per mom's request. Referred to Northside MENTAL HEALTH Services for behavior

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
	Panno Center or Northside MENTAL HEALTH Services as recommended before					modification and counseling. Stop waking up in middle of night to use restroom. Use reward system or bed alarms. F/U end of [3 months] with last report card.
3 months	no evidence of hyperactivity, impulsivity, or lack of attention span;	ADHD combined; ODD	Focalin 10mg XR qam	none	School behavior improved after increasing dose; other students “better able to get along with” him. Straight As. Still poor behavior at home; aggressive without the Focalin; recommendation to increase Focalin to 10 mg, not done till end of April; nocturnal enuresis	Continue Focalin on daily basis. Referred to Northside MENTAL HEALTH Services for behavior modification and counseling – not followed up on before. F/U in [4 months].
5 months	no evidence of hyperactivity, impulsivity, or lack of attention span;	ADHD combined; ODD	Focalin 10mg XR qam	none	Straight As; occasional bad days, talks out of turn, makes faces behind teacher’s back; attentive in class; apologetic for poor behavior; no f/u on referral for counseling; nocturnal enuresis	Continue Focalin F/U in [5 months] with copy of first and second report cards.

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
6 months	no evidence of hyperactivity, impulsivity, or lack of attention span;	ADHD combined; ODD	↑ Focalin 15 mg XR qam	none	mo. did not bring report card; reports straight As; being tested for gifted program; behavior poor at home and at school; makes faces behind teacher's back; (no mention of nocturnal enuresis in this note)	↑ Focalin to 15mg XR qam. Refer for counseling. F/U in 2 months with copy of third report card.
5 months	lost to f/u since 3/08; no evidence of hyperactivity, impulsivity, or lack of attention span; Mo. did not notify office of side effects	ADHD combined; ODD	Δ to Vyvanse 30 mg qam	↓appetite, difficulty initiating sleep, subdued mood. Happier not on med.; "comes off" the med. early evenings he is irritable and grumpy.	Straight As; behavior issues home and school; mom concerned he is too rough; received counseling over summer – mom not sure if helpful.(No mention of NOCTURNAL ENURESIS)	Δ to Vyvanse 30 mg qam. F/U with counseling and behavior modification. Inform of any side effects. F/U in 4 weeks.
3 months			Focalin			
3 weeks			Vyvanse			
4 months			Clonidine Wellbutrin			

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
2 weeks	discontinue Wellbutrin		Strattera		not doing well; not taking Clonidine or Wellbutrin; has trouble sleeping and bedwetting;	
5 months	ARNP noted “not looking at me like last time; watching t.v. intently with frown. Not his usual.”	ADHD Enuresis Anxiety	Strattera Focalin		poor choices; poor judgment; issues with peer; does not feel accepted	
2 months	no change needed	ADHD Mood Disorder (Anger)	Focalin 20 mg Strattera 18 mg	constipation	mom seems to have concerns, but is o.k.; not sleeping good	
5 months		ADHD Enuresis	Focalin 20 mg Strattera 18 mg DDAVP .2 mg		teacher has concerns about focusing and day dreaming; can't follow instructions.	
1 month		ADHD Mood Disorder (Aggressiveness) Enuresis	Focalin 20 mg and Intuniv 1 mg	none	still wetting the bed – mom wants further tests done; no complaint from teacher yet; no problems reported; just some	

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
					issues; not sleeping good	
3 months			DDAVP .2 mg increase to 2 tablets stopped meds for summer		mom stopped giving DDAVP because didn't work and doesn't want child to take meds; feels is not good to take meds. However says embarrassed. Mo feels he needs work-up because still wets the bed. No other urination problem when awake. Also sleep walk at night.	Education re: nocturnal enuresis. Reassured. Try bed alarm.
1-1/2 months	mom finds barrier to every suggestion	ADHD	none		mom very upset bedwetting continuing; not giving DDAVP meds – can't afford bed alarm – can't wake him up from deep sleep to get up to void at night.	no caffeine, limit evening fluids, refer to urology
1 week		ADHD	DDAVP Focalin 20 mg Intuniv 2 mg		aggravates others; always touching someone; doesn't listen	

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
2 months	Conners Scale score: 24		Strattera starter pack Focalin back to 20 mg		moody; mom giving him Focalin 30 mg; problems in school; biting nails/not sleeping good; can't wait for anything; misbehaves; constipated	
1 month		ADHD	Strattera Zantac		nauseated; broke out in sweat;	
2 weeks	lost to f/u since 8/08	ADHD combined; ODD; Sleep D/O Hx of abnormal EEG	Focalin 30 mg XR qam Strattera 60 mg qhs Zantac 150 mg	↓appetite, occasional headaches;	biting nails, emotionally labile, unhappy over past 2 years, doesn't like school, struggles socially, grades have dropped, bored, poor focus; angers easily, hyperactive, easily frustrated, disrespect-ful. Difficulty initiating sleep; restless sleep. Has been on Focalin, Vyvanse, Concerta, Strattera, and Intuniv. Off meds in summer and mood improves. PSG last year – no results.	24 hr. LTM to better assess abnormal EEG findings. MRI of the brain, plain. Taper off Strattera. ↓ Focalin to 20 mg qam. Start Abilify 2 mg qhs to be ↑ to 5 mg qhs after a week. F/U in 4 weeks with report cards and school notes.
3 weeks	no evidence of hyperactivity, impulsivity, or lack	ADHD combined; ODD	Abilify 2 mg stopped 12/07/10	stomachache, burning in back and top of mouth, right	Mo. reported this medication worked better than any other; focus and	Abilify 1 mg bid. Vasculitis work-up to include CBC, CMP, ANA,

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
	of attention span;	Sleep D/O Hx of abnormal EEG		arm pain, occasional headaches.	behavior were improved, old personality back.	B12, folate, RF, ESR, lipids, and thyroid panel. 24 hour LTM. MRI. F/U in one month.
Testing - 2 weeks	long-term audio/video EEG telemetry – 20 hr period – multiple samples – normal. MRI normal. Blood work not back.	ADHD combined; ODD; Sleep D/O	Abilify 1 mg			Continue Abilify 1 mg. F/Y as scheduled.
2 weeks	no evidence of hyperactivity, impulsivity, or lack of attention span;	ADHD combined; ODD; Nocturnal Enuresis	Abilify 1 mg	previous aches and pains stopped;	school going well; mo. happy with medication, increased appetite, nocturnal enuresis. Mom wakes up 2x per night.	Continue Abilify. Get lab results. Limit fluid intake after 6 pm. F/U 3 months with report cards.
1 month	no evidence of hyperactivity, impulsivity, or lack of attention span;	ADHD combined; ODD; Nocturnal Enuresis; Possible RAD	discontinued Abilify 1/31/11 Geodon 20 mg qd	elevated LFTs made him depressed, sleepy, uncontrollable crying after few	Behavior at school is poor. Will start counseling soon. Nocturnal enuresis. Has been on Abilify, Geodon, Focalin, Concerta, Strattera, Vyvanse, and Intuniv – all with little success.	Tx Plan: Discussed past, adoption, abandonment issues, in and out of foster care. Referred to child psychiatrist. Kapvay .1mg qhs to be increased to bid after a

<input type="checkbox"/> neurologist <input checked="" type="checkbox"/> pediatrician						
Time Between Appts.	Exam Notes	Diagnosis	Medication	Side Effects	Behavior	Recommendations
			Kapvay	days, stopped		week. Note for school to work with us in accommodating behavior. DDAVP .2 to .4 mg qhs to help with nocturnal enuresis. Encouraged mom to get counseling ASAP. F/U in 4 weeks.
1 month	no evidence of hyperactivity, impulsivity, or lack of attention span;	ADHD combined; ODD; Nocturnal Enuresis	Off meds for time being	Kapvay lead to sensory issues in the skin; very sensitive and skin hurt; abdominal pain and headaches. Off for 5 days. Did not improve his behavior	not accepted into gifted program due to academic difficulties; mother discontinued DDAVP .4mg. Continued nocturnal enuresis.	Plan: CBC, CMP, hepatitis panel. Remain off meds – follow thru with psychiatric eval. [2 weeks]. F/U in [3 months].