Psychotherapy: Theory, Research, Practice, Training
2004, Vol. 41, No. 4, 487–495

0033-3204/04/$12.00 DOI 10.1037/0033-3204.41.4.487

THE TREATMENT OF DISSOCIATION IN SEXUALLY ABUSED CHILDREN FROM A FAMILY/ ATTACHMENT PERSPECTIVE

JOYANNA L. SILBERG
Sheppard Pratt Health System

This article outlines an approach to treatment of sexually abused children with dissociative symptoms. Dissociated self-states are seen as competing interpersonal approaches to handling the many emotional sequela of abuse, including anger, fear, and regressive needs. Parents' responses to their sexually abused children, complicated by guilt and their own histories of trauma, can promote dissociative coping in the children as they have difficulty processing their own real feelings of anger, fear, and responsibility. Children and parents may alternatively take victimizer, victim, and rescuer roles, thus mutually reinforcing a dissociative style of coping with these events. This article illustrates how sensitivity to these family dynamics, along with a problem-solving approach to the child's symptoms, can treat dissociative psychopathology in these children.

Dissociative symptoms in children and adolescents have been described increasingly as a sequela of various traumatic experiences, including physical abuse, medical trauma, exposure to violence (Dell & Eisenhower, 1990), infantile neglect (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997), war trauma (Cagiada, Cammaido, & Pennan, 1997), and sexual abuse (Coons, 1994; Johnson, 2002; Stien & Kendall, 2004). Dissociative symptoms may include a child entering trance-like states, showing forgetfulness for past or current behavior, having fluctuating behavior including rapid regressions, rage reactions, beliefs in vivid imaginary friends or divided identities, and symptoms of depersonalization and derealization. While theoretical writings have often associated dissociative symptomatology in children with sexual abuse experiences, studies have failed to demonstrate that there is a necessary or exclusive relationship between sexual abuse experiences and dissociative symptomatology (Ogawa et al., 1997; Rhue, Lynn, & Sandberg, 1995). Nonetheless, a history of sexual abuse is often found in children who display dissociative symptomatology, and treatment of patients with these histories can be enriched by an appreciation of the relationships between sexual abuse events and the manifestations of these various symptom patterns.

This article looks at dissociative symptoms in sexually abused children from a complex and multidimensional standpoint. The theoretical model underlying this treatment approach assumes that dissociative symptoms are complex adaptations that evolve into learned habits that are then reinforced in environments in which parent–child interaction patterns continue to promote and reinforce maladaptive functioning. The important role of families and how they deal with children's sexuality, sexual behaviors, and sexual experiences is heavily stressed, as this is seen as the primary force that shapes dissociative adaptations in sexually abused children over time. While cognitive–behavior therapy has been em-

Joyanna L. Silberg, Sheppard Pratt Health System, Baltimore, Maryland.

Correspondence regarding this article should be addressed to Joyanna L. Silberg, 6501 North Charles Street, P.O. Box 6815, Baltimore, MD 21285-6815. E-mail: jlsilberg@aol.com

pirically validated for work with sexually abused children, it may be necessary to incorporate more complex approaches into the treatment when dealing with severely or chronically traumatized children in complex situations (Saywitz, Mannarino, Berliner, & Cohen, 2000). I first give an overview of the *integrative developmental model*, relate recent attachment research and theory to the various coping styles of sexually abused children in interaction with their families, and then suggest treatment strategies through an illustrative case example. These treatment strategies help to disrupt these maladaptive coping styles by teaching parents and children to appropriately process feelings and ideas related to the children's sexual abuse experiences.

Integrated Developmental Model

The integrated developmental model is an approach to dissociative pathology that recognizes the complex etiological roots of these symptom patterns (Silberg, 2002). There is no assumption that fragmented identity or dissociative defenses are activated at static moments of time during traumatic experiences; instead, the development of these symptom patterns is viewed as a long-term developmental process occurring within an interpersonal environment. Newer theories of self-development stress that shifting multiple self-states are normal phenomena. Theorists have stressed that dissociative patients are unable to manage the inevitable conflicts between these self-states or roles or to develop cohesive organization across state shifts (Bromberg, 1998; Putnam, 1997). The integrated developmental model stresses that it is the interpersonal environment in which the child resides that accentuates the conflicts in these self-states and impedes the development of an integrated self that could more easily process strong emotions and painful experiences. The dissociative symptoms are the manifestations of these integrative failures, so that consciousness is erratic (trance states), relevant information is discarded (forgetfulness), and conflicting, unprocessed emotions dictate behavior (fluctuations in identity or behavior).

I have speculated that children who are at risk for dissociative symptomatology have a unique composite of traits and abilities. These capacities include symbolic skills, fantasy-proneness (Rhue, Lynn, & Sandberg, 1995), empathic perceptiveness, and social traits such as social compliance or high attachment needs that are related in part to the capacity for trance induction (Silberg, 1998). One might speculate that a child who has experienced sexual abuse from a trusted adult might be receiving conflicting messages about attachment ("You are loved by me" vs. "You are an object to me"). The child who is particularly sensitively attuned to these conflicting messages may learn a pattern of disavowal and disconnection from this conflicting information, facilitated by skill at trance-induction and ability to use fantasy for escape and coping. The sexual experiences themselves may also be trance-inducing and serve as a form of rehearsal of state-dependent learning, as the unique and specific physiological state of sexual arousal becomes associated with specific behaviors and conflicting attitudes—loving feelings and wanting to please the other, as well as helplessness and anger. This pattern of dissociation can become habitual over time in environments that discourage the resolution of these conflicting emotions. This model suggests that a full treatment approach must involve learning a new pattern of attention to internal cues so that the habit of dissociating information is replaced with attending to important emotional, cognitive, or perceptual information that will promote a more healthy adaptation. This new pattern can only occur if the environment fully supports recounting what happened, understanding what happened, and freeing the child from all of the mixed messages and symbolic meanings that the child's behavior may have for the family.

The integrated developmental model takes very seriously the potential suggestive social influences that may affect behavior, stressed by the sociocognitive critique of dissociative identity disorder therapy (Lilienfeld et al., 1999). However, the family environment is viewed as the primary place where dissociation can be supported through family interaction styles. Parents who may view their children as "wicked," "oversexualized," or "babyish" may unconsciously encourage the children to enact these fluctuating roles. Children who have been sexually abused may be even more suggestible and susceptible to this kind of environmental reinforcement. Their needs for attachment have been gratified in relationships in which they have learned to accommodate to the expectations of powerful others. They, therefore, may not have developed the in-

ternal self-regulation that healthy development requires.

To counter these environmental forces, the therapist (as presented here) encourages the development of autonomy, self-direction, and resistance to suggestion. If dissociation can be encouraged by therapist influences, as the sociocognitive model suggests, how much more invasive might it be for families to support and embellish conflicting attributions about their children in the suggestive and powerful domain of family life? Thus, the family expectations and beliefs that sustain a particular view of the child and his or her role in the family need to be understood and explored in the treatment.

Recent research suggests that children with disorganized or avoidant attachment styles might be particularly at risk for developing dissociative symptomatology (Ogawa et al., 1997). Thus, enhancing parent–child attachment patterns and communication becomes important. Family interventions involve enhancing reciprocity in communication, encouraging direct expression of feeling, and avoiding the reinforcement of regressive coping. The therapist models for the child and family interactive styles that encourage wholeness, responsibility, and tolerance for the expression of feelings.

The traumatic roots of these dysfunctional patterns are appreciated, but processing traumatic memories is not the primary goal of this treatment approach. Instead, the way that the ongoing unprocessed traumatic associations continue to affect the child's choices and self-views is the primary emphasis in treatment. The therapy setting provides an opportunity to examine the distorted self-perceptions that have originated in the traumatic circumstances and to see how those perceptions color current behavior and reactions. For the sexually abused child, these views may include a sense of being "dirty" or "evil," "a helpless victim," or "loved" only for one's sexuality or ability to give others pleasure. Examining these self-perceptions becomes important because they may precipitate dissociative withdrawal, sexualized behavior, or regressions when elicited by events or current interactions with others. The integrated developmental model emphasizes learning about the moments when the child tries to cope by use of dissociative "switches" so that the information that is being dissociated can be acknowledged, understood, and assimilated. This approach also emphasizes the environmental stressors that make a dissociative strategy adaptive for that individual and attempts to minimize these stressors in the child's environment. For example, some families with poor tolerance for expression of angry affect may be accustomed to angry expressions only in the form of uncontrolled rage. Creating opportunities where anger can be expressed safely and in a controlled way teaches the whole family new tools for managing affect. Some families inadvertently reinforce regressive behaviors as the only way for the child to get needs met for nurturing. The family can learn to encourage more mature expressions of need and to set new family patterns.

According to Siegel (1999), who wrote about dissociative processes from a neurobiological perspective, "interpersonal processes can facilitate integration by altering the restrictive ways in which the mind may have come to organize itself" (p. 336). Thus, therapeutic intervention provides new interpersonal contexts for the child in interaction with the therapist, and in therapeutic interaction with the family, which provides incentives to develop a more coherent self. Treatment involves emphasizing self-awareness and affect regulation and encouraging the child to take responsibility for actions initially perceived as outside of his or her control. Interactions with the child emphasize acceptance of all affects, behaviors, or dissociated states and encourage self-acceptance as a first step toward self-management. Treatment is guided by normal developmental expectations and avoids iatrogenic influences that support the child or family's belief in the literal reality of dissociated identities.

This treatment approach avoids a diagnostic orientation to assessment of dissociation in children. Childhood manifestations of dissociation do not fit into the clear-cut adult categories described in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; Silberg, 2000). Trying to describe children within the confines of these categorical descriptions may only constrain our understanding of the full context in which these dissociative behaviors may appear. Instead, a symptom-based approach is encouraged in assessing children and adolescents, and a treatment perspective is encouraged that addresses the individual symptoms themselves while remaining mindful to the broader meaning these symptoms may have within the child's family. This symptom-based model of assessment is consistent with the guidelines of the International Society for the

Treatment of Dissociation (ISSD; in press) as well as newer approaches to therapeutic guidelines (Beutler, 2000).

Attachment and Dissociation

The longitudinal research of Ogawa et al. (1997) and Carlson (1998) have demonstrated a robust relationship between early infant and childhood experiences and the development of dissociative pathology into late adolescence. Those children who demonstrated disorganized and avoidant attachment styles and who experienced parental neglect were more likely to display pathological dissociation in follow-up as young adults. Liotti (1999) developed a theoretical model to explain how dissociative processes might relate to these impaired patterns of attachment. According to Liotti's conceptual model, dissociation can best be viewed not as a defensive reaction but as a failure in integration of the normal processes of "intersubjectivity" that develop between a child and a caregiver, a failure of personal synthesis in the development of meaningful self-understanding in relation to others. Liotti hypothesized that those individuals whose caretakers are fearful and frightened may elicit multiple, competing internal working models or schemata of expectation in the caregiving relationship. Because of competing schemata, these individuals see themselves as the cause of pain to the caregiver (persecutor), the victim of harm from the caregiver (victim), or the soother and rescuer of the caregiver (rescuer). These competing schemas may be experienced simultaneously or in rapid succession, leading to confusion, impaired integration, and the "freezing" or dissociation observed in young children with disorganized attachment. Liotti further hypothesized that this impaired attachment style makes it more difficult for an individual to be able to seek comfort after a traumatic event. A feedback loop of increasing fear is created by the attempt to seek comfort while simultaneously being stymied by the unavailability of consistent comfort. Liotti emphasized that the dissociative reaction may be seen as a failure of being able to develop an organized response to the dilemma of the need for attachment and soothing, when such soothing is inconsistently available. Liotti further suggested that when the traumatic event happens within the family, the expectation of a dissociative reaction would be even more profound.

Liotti (1999) found confirmation for his theories relating disorganized attachment to dissociation by noting that the early multiple reactions of the child as persecutor, victim, and rescuer are also commonly observed dissociated roles in patients with dissociative identity disorder. Davies and Frawley (1994) have described similar constellations of countertransferential reactions elicited by dissociative patients in a therapeutic setting. Liotti noted that it is not only the child in reaction to the parent who develops these competing and disorganized roles (persecutor, victim, and rescuer) but also the frightened parent who shifts between these multiple roles, further confounding the child's search for consistent gratification and comfort.

Families dealing with the trauma of sexual abuse of a child provide an excellent illustration of the processes by which these multiple and competing reactions on the part of the parent and the child interfere with the natural soothing and processing that allows healthy functioning to resume after trauma. Sexual abuse experiences of a child arouse so many competing feelings, desires for secrecy, memories of one's own victimization and sexual experiences, and confused and ambivalent emotions in the child and the parent that similar processes to those described by Liotti (1999) may occur. This is likely to be the case whether the conflicting feelings are a result of abuse within the family or from maltreatment by an individual outside of the family. In either case, these competing processes lead to dissociative manifestations, forgetting, and inability to make adequate meaning out of the feelings, perceptions, and ideas stimulated by the sexual abuse.

As Liotti (1999) stated in a paraphrase of Bowlby,

> Lies, deceptions, and other sources of seriously distorted family interactions force the growing child to exclude new and potentially meaningful information, already stored in the implicit or in the episodic memory system, from communication, and therefore from semantic processing and from conscious thought. (p. 307)

Families dealing with sexual abuse can easily establish an environment in which deception and distortions interfere with the integration of information required for healthy, integrated development.

In a fascinating and perceptive article by Maker and Buttenheim (2000), the authors described how parenting difficulties can emerge among sexual abuse survivors when trying to deal with normal parenting responsibilities in

which issues of aggression, sexuality, and limit-setting will naturally emerge. In their case description, they show how a mother's sexual abuse history led her to engage in multiple and vacillating roles with her child. She alternately overidentified with the child as victim, saw him as a perpetrator, and became flooded with memories of her own shame, guilt, and responsibility to rescue him. These fluctuating pulls rendered her helpless to intervene effectively as a parent. The authors' treatment approach involved parenting education and role plays to break the cycles of reenactment, gradually increasing the mother's competence and belief in her own parenting success and helping her diffuse and process the intense anxiety about her own history that the child's behavior aroused.

Children who have been sexually abused activate similar dynamics in their parents whether the parents have or have not been victims of sexual abuse themselves. The issues aroused are complex and personal and stimulate any distorted self-views and feelings of inadequacy harbored by parents. In my experience, working with parents to help them come to terms with their own responses to the sexual abuse experiences of the child is necessary for healing. This process interrupts the dissociative reactions that emerge in parent–child interactions that become rigid reciprocal enactments of the worst fears and beliefs of parent and child about who they are and what they can expect in relationships. Careful examination of some of these family dynamics partly substantiates Liotti's (1999) theories about the competing and multiple reciprocal roles that parents and children may display following trauma that prevent restorative soothing. As illustrated later in this article, these multiple and competing parental views of self and child both lead to and sustain dissociative processes in these families.

The following case study explores how the internal working models described by Liotti (1999) as the basis for disorganized attachment and dissociation in infancy can also characterize parental responses to the sexually abused child. The resulting interactive pattern leads to an environment that fuels dissociative adaptations in a child struggling to make meaning out of the experiences of abuse while also grappling with the confusing and conflicting reactions of the caregiver. Parents identify with the child as a victim while feeling victimized themselves by their child. They may also identify with the abuser and blame the child for behavior that is a consequence of sexual abuse or, alternatively, may overly identify with the need to rescue the child or be rescued by the child. All of these stances interfere with the child's ability to make meaning out of the experience of sexual abuse, integrate it, and move on.

Case of Betsy

Betsy, age 11, was referred for treatment for "sexual offending" behavior toward girls her age and younger. When her father had become violent toward her mother after 6 months of marriage, her mother separated from him. Following a court-ordered visitation with her father at age 2½, Betsy stated that "Daddy touches and licks my Suzie."

Despite repeated protective service reports and court hearings over the next several years, visitations continued. At age 6, Betsy described parties at her father's house during which many men would sexually abuse her. Now more articulate, Betsy was able to provide graphic details that finally led to substantiation of her report by the state child services department. The judge who had been hearing the case had retired. The new judge reversed the court's previous findings, halting visitation with the father. Betsy's father agreed to terminate parental rights in return for assurance that no criminal charges would be filed.

Although Betsy received therapy over the next several years, her problems began to escalate at age 11. She became fearful of attending her new middle school and had great difficulty getting up in the morning, entering trance-like states lasting up to 2 hr in which she was unresponsive to her mother. She also reported hearing voices in her head that ordered her to make sexual advances toward other children. The trance-like states and voices suggested the presence of dissociative processes.

A symptom-based assessment approach suggested that immediate intervention was required in the areas of school refusal and sexual acting out. Careful analysis helped elucidate many levels of feelings that contributed to these behaviors. Betsy stated that when her mother yelled at her to get ready in the morning, it reminded her of the years of forced visitation. She reported that she heard voices in her head yelling at her not to go and not to listen to her mother. She explained that

she would silence these voices by tuning them out and becoming "out of it."

Betsy was asked to attend more carefully to what these voices were telling her. She identified one that told her to comply because her mother was right, one that urged her to hit and defy her mother, and a childlike voice that said she was too young to go to school. These three voices correspond to the three relationship orientations described by Liotti (1999) as underlying attachment conflicts of dissociative patients: victim, victimizer, and rescuer. To interrupt the "shutdown" resulting from these competing working models and strengthen the attachment relationship, the therapist encouraged Betsy to communicate each of these conflicting perspectives to her mother, allowing her mother to hear and respond to her daughter's concerns.

Next, a careful analysis was conducted of Betsy's mother's reactions to these events. Mother stated that she was furious at Betsy for not going to school and for making her late for work, complaining that she felt helpless when Betsy entered trance states. These encounters reminded her of her helplessness when the court ordered her to let Betsy visit her father even though she knew she was being abused. She expressed overwhelming guilt about letting her daughter down and a strong need to rescue and soothe her, which inhibited her from being firm about school attendance. These conflicting impulses suggest that Betsy's mother also experienced all three stances described by Liotti (1999): a desire to punish for not doing the right thing (victimizer), a feeling of helplessness and immobilization (victim), and a pull to protect (rescuer).

Therapy provided the opportunity for these conflicting attitudes to be expressed. During a family session, Betsy's mother was encouraged to remember times when she was forced to send Betsy to her father and how powerless and angry Betsy must have felt. Although this was very difficult for her, she was encouraged to empathize with the rage and helplessness her daughter felt at those moments. She was asked to listen to Betsy's description of these feelings and to see "the little 5 year old" in Betsy that so much wanted a "mommy" to keep her safe. Betsy responded by sobbing deeply; her mother was asked to simply tolerate this, hug her, and let her cry as she experienced these painful feelings. In allowing this expression, Betsy's mother provided the kind of soothing comfort that she was not able to supply in the past.

Betsy was also encouraged to express her anger at her mother for restricting her from social events at school due to her mother's fears that Betsy would victimize others. Betsy's mother was prompted to listen to Betsy's complaints. The two of them negotiated how Betsy could ensure that she would not endanger others while attending these activities.

In order to avoid having Betsy's mother burden Betsy with her own overwhelming feelings about past events, the therapist addressed these feelings in individual sessions. These sessions provided Betsy's mother with a forum to safely express her own rage and frustration at what had happened to her and her daughter. The opportunity to sort out and come to terms with her own feelings helped her avoid reacting to Betsy's hesitancy to attend school in a manner that had contributed to Betsy's "shutdown" response, fortifying the attachment relationship.

As Betsy learned to express her conflicting feelings to her mother, she no longer heard the battling voices in her mind. As a behavioral intervention for the morning trance states, Betsy's mother was told to simply ask her once to go to school and then to monitor the length of time it took for Betsy to come out of the trance by herself. This approach placed Betsy in charge of her own behavior and diffused her mother's frantic sense of helplessness. Betsy's mother was taught how to set up a reward system for school attendance and punctuality. Contact with the school explaining the intervention secured their cooperation; Betsy was freely given late passes during her initial week back at school as she was adjusting to regular attendance. In response to these simple interventions, Betsy was attending school on time within 1½ weeks.

Nevertheless, Betsy still reported hearing a voice in her mind that told her to do sexual things to others. With encouragement to listen more carefully to this voice, she reported that it was conveying that this was the way to get close to people and keep them from abandoning her. These meanings of sexual behavior were related to the momentary relief from her father's violence that she experienced during sexual molestation by him. By identifying these feelings, Betsy was able to articulate other ways to manage her need for closeness and fear of abandonment by friends. She learned to recognize when these

feelings arose and to find outlets for them other than sexualized behavior.

Emphasis was placed on education about sexual matters, an important component of treatment for sexually abused children (Wieland, 1998). Betsy was told that rather than reject her sexuality as "bad," she should learn to value this part of herself to which she had been introduced by her father "way too young." As she explored these feelings, she no longer heard the voice talking to her and increasingly experienced these behaviors as being under her own control.

It became clear that Betsy's mother's characterization of Betsy as a "sexual offender" implied that Betsy was destined to become like her father. By rejecting Betsy and her behavior, she temporarily alleviated her own guilt about the visitations during which Betsy had been abused. Reframing Betsy's sexual behavior as being motivated by a desire to obtain closeness and avoid abandonment helped Betsy's mother view it in a less pejorative way. Open communication between Betsy and her mother about sexual matters helped reduce the dissociation that had been fostered by treating sexuality as shameful and secretive. They were able to establish an agreement that Betsy would go to her mother when she felt sexual impulses toward other children, so that increased closeness with her mother could alleviate her lonely feelings and fears.

As treatment progressed, Betsy began to have posttraumatic nightmares in which she relived some of the instances of sexual abuse in her father's house. Initially, she recorded these dreams and memories in a notebook, but in therapy she was encouraged to add commentaries on what she might do now or how she could now see these events differently. Dealing with the memories in this way emphasized coping and mastery, helping Betsy overcome the fear and horror she had previously experienced. Eventually, as feelings about the unfairness that her father had never been punished began to surface, she and her mother were encouraged to share their rage about this without taking it out on each other. When inevitable fights occurred between the two of them, they were taught how to give each other space, sort out conflicting feelings separately, and seek help as needed from therapists. After 10 months of treatment, all dissociative behaviors, school refusal, and sexual acting out had ceased as intense scenarios that activated old feelings were defused and the family learned to communicate more effectively.

Clinical Implications

Conceptual Implications

The case of Betsy illustrates several important points about sexually abused children who exhibit dissociative symptoms. This vignette shows how issues of sexual abuse raise excruciatingly intense feelings in families. When unexpressed, these feelings are enacted in subtle ways that can set the stage for the development of a dissociative response style in the abused child. While the sexual abuse experiences themselves may foster dissociation, the subsequent fall-out created by the way the family reacts to these events can further contribute to dissociative symptom formation.

These are complex cases that require appreciation of the entire context in which the abuse occurred. The memories of the sexual abuse events themselves almost pale in comparison to other parent–child issues that emerge in processing an account as painful as Betsy's and her mother's. Dissociation in cases such as this can be understood as an activation of intense attachment conflicts from which neither mother nor child knew how to extricate themselves. Conflicted and powerful affect that each experienced triggered the other into equally intense and countervailing feelings. These feedback cycles promote dissociative shutdown that may be reminiscent for the child of earlier traumatic times when he or she would retreat into a trance-like state. In Betsy's case, the traumatic events of the sexual abuse and the forced separation from her mother triggered her dissociative response style.

Treatment Implications

Dissociation in children is usually promoted by a dyadic relationship in which multiple competing models of self and other are in conflict. Unraveling these conflicts requires a careful combination of family and individual symptom-based approaches. When meaningful information about past and current feelings is communicated, an atmosphere is created that counteracts dissociative shutdown and fragmentation. A symptomatic approach to Betsy's sexual acting out and school avoidance, for example, led to clarification of the feelings behind these difficulties. This, in turn, allowed these feelings to be communicated and

ultimately allowed Betsy to obtain the soothing she was seeking. In contrast, a more simplistic conceptualization might have exclusively viewed Betsy's dissociation as having been rigidly fixed during the traumatic events. Such an approach might have missed the subtle interpersonal factors in the family that reinforced and maintained the dissociative coping behaviors.

To address these various contributors to dissociative responding, one needs a comprehensive treatment perspective that includes three major foci: (a) addressing symptoms directly, (b) conceptualizing symptomatic behaviors as expressions of unstated contradictory pulls and feelings within the child and in the family system, and (c) promoting communication so that family members can come to terms with the painful secretive feelings they harbor about the meaning of having a child who has been sexually abused. Failure to confront these real and complex issues places the children at risk for resorting to expressing confused feelings through dissociative states or identity fragments. While dealing with the traumatic material itself is a desensitizing and empowering component of the treatment, in these complex cases in which dissociative processes are evident, the layers of dissociated feelings and attitudes among the parents must also be confronted and expressed.

Sociopolitical Implications

In the aftermath of the sexual abuse of a child, one of the factors that families must confront is the disturbing reality that it is very difficult to get a conviction for sexual offenses against children. This scenario challenges these families, for it means that on one level they are coping with society's dissociation of the harm that some will do to children. Why should Betsy and her mother, on top of everything else they had to come to terms with, have to face that the men who hurt her will never be held responsible for the damage they have done?

Through their symptoms, children display the conflicts and contradictions inherent in the unsafe world around them. In situations such as Betsy's, children may express their rage at the betrayal and lack of safety and protection they experience through disowned parts of the self. On one level, in its ambivalent and contradictory approach to providing safety and nurturing to its own children, our society may be seen as fostering the "disorganized" attachment described by Liotti (1999).

References

BEUTLER, L. E. (2000). When empirical and clinical standards of practice meet. *American Psychologist, 55,* 997–1007.

BROMBERG, P. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation.* Hillsdale, NJ: Analytic Press.

CAGIADA, S., CAMMAIDO, L., & PENNAN, A. (1997). Successful integrated hypnotic and psychopharmacological treatment of a war-related post-traumatic psychological and somatoform dissociative disorder of two years duration (psychogenic coma). *DISSOCIATION, 10,* 182–189.

CARLSON, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development, 69,* 1107–1128.

COONS, P. M. (1994). Confirmation of childhood abuse in childhood and adolescent cases of multiple personality disorder and dissociative disorders not otherwise specified. *Journal of Nervous and Mental Disease, 182,* 461–464.

DAVIES, J. M., & FRAWLEY, M. G. (1994). *Treating the adult survivor of child sexual abuse: A psychoanalytic perspective*. New York: Basic Books.

DELL, D. F., & EISENHOWER, J. W. (1990). Adolescent multiple personality disorder: A preliminary study of eleven cases. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 359–366.

International Society for the Study of Dissociation. (in press). Guidelines for the valuation and treatment of dissociative symptoms in children and adolescents. *Journal of Trauma and Dissociation, 5*.

JOHNSON, T. C. (2002). Some considerations about sexual abuse and children with sexual behavior problems. *Journal of Trauma and Dissociation, 3*(4), 83–105.

LILIENFELD, S. O., LYNN, S. J., KIRSCH, I., CHAVES, J. F., SARBIN, T. R., GANAWAY, G. K., & POWELL, R. A. (1999). Dissociative identity disorder and the sociocognitive model: Recalling the lessons from the past. *Psychological Bulletin, 125,* 507–523.

LIOTTI, G. (1999). Disorganization of attachment as a model of understanding dissociative psychopathology. In J. Solomon & C. George (Ed.), *Attachment disorganization* (pp. 291–317). New York: Guilford Press.

MAKER, A. H., & BUTTENHEIM, M. (2000). Parenting difficulties in sexual abuse survivors: A theoretical framework with dual psychodynamic and cognitive–behavioral strategies for intervention. *Psychotherapy, 37,* 159–170.

OGAWA, J. R. SROUFE, L. A. WEINFIELD, N. S., CARLSON, E. A., & EGELAND, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology, 9,* 855–979.

PUTNAM. F. W. (1997). *Dissociation in children and adolescents.* New York: Guilford Press.

RHUE, J. W., LYNN, S. J., & SANDBERG, D. (1995). Dissociation, fantasy and imagination in childhood: A comparison of physically abused, sexually abused, and non-abused children. *Contemporary Hypnosis, 12,* 131–136.

SAYWITZ, K. J., MANNARINO, A. P., BERLINER, L., & COHEN, J. A. (2000). Treatment of sexually abused children and adolescents. *American Psychologist, 55,* 1040–1049.

SIEGEL, D. J. (1999). *The developing mind*. New York: Guilford Press.

SILBERG, J. L. (1998). Afterword. In J. L. Silberg (Ed.), *The dissociative child* (2nd ed.). Lutherville, MD: Sidran Press.

SILBERG, J. L. (2000). Fifteen years of dissociation in maltreated children: Where do we go from here? *Child Maltreatment, 5,* 119–136.

SILBERG, J. L. (2002). Treating maladaptive dissociation in a young teenage girl. In H. Orvaschel, J. Faust, & M. Hersen (Eds.), *Handbook of conceptualization and treatment of child psychopathology* (pp. 449–474). Oxford, United Kingdom: Elsevier Science.

STIEN, P. T., & KENDALL, J. C. (2004). Psychological trauma and the developing brain: Neurologically based interventions for troubled children. Binghamton, NY: Haworth Press.

WIELAND, S. (1998). *Techniques and issues in abuse-focused therapy.* Thousand Oaks, CA: Sage.