
The Neurosequential Model in Caregiving[®]

The NMC Ten Tip Series Understanding Dissociation

One of the most powerful and important mental mechanisms we have to help us regulate is 'dissociation.' The ability to disengage from the external world and retreat into your inner world - along with all of the complex physiological changes that go with that - is one of the primary ways we respond to stress, distress and trauma. The other major component of our complex stress response capabilities is the more commonly discussed 'fight or flight' (or Arousal) response, which we discuss in a separate NMC Ten Tip Series edition, *Understanding Hyperarousal: The 'Flock, Freeze, Flight and Fight' Continuum*. Both of these response patterns – dissociation and arousal – work together to help us stay in equilibrium with everyday stressors and to survive extreme experiences.

When any individual experiences extreme or prolonged distress (e.g., when physically or sexually abused) or patterns of unpredictable and uncontrollable stress (e.g., with poverty, community violence), these stress response systems can become 'sensitized.' They become overactive at baseline and overly reactive when activated. If the traumatic experiences are inescapable, unavoidable and painful the major stress response will include dissociation. This dissociative response helps to prepare the body for 'injury' by decreasing heart rate and circulation to non-essential parts of the body. A release in the body's opioids (enkephalins and endorphins) contributes to a disengaged, time-distorted, and pain-insensitive state. The mental retreat into a safer, inner world may also occur; if these inescapable traumatic experiences occur frequently, the child may create an elaborate fantasy 'place' where they may assume a persona of a more powerful character or animal. Themes of power and powerlessness, retribution and justice are common in this 'safe' inner world.

When abuse and neglect is experienced in infancy and early childhood, and when painful and inescapable abuse occurs (e.g., sexual abuse), sensitized dissociative systems are common. The manifestations of this include shy and avoidant interpersonal interactions, overly compliant or robotic interactions when directly engaged; frequent somatic symptoms (e.g., headache, abdominal pains) and frequently observed 'daydreaming', 'tuning out' and 'being in their own world.' Because these children often just 'check out' when engaged by adults, they can be among the most confusing and challenging to work with in therapy and in the home.

Here are few practical tips for those living and working with children demonstrating some forms of 'sensitized' dissociative response.

1. Quiet & shy is sometimes actually 'shut-down.' At 'baseline' these children tend to be avoidant. They tend to be overly sensitive to conflict and chaos. Raised voices, even in excitement, can push these children to shut down. Eye contact will be avoided; they may not seek adult interactions and when they do, they will often demonstrate 'overly' compliant or capitulation behavior that demonstrates submission. I have had children and youth with sensitized dissociative adaptations say that they wished they were invisible; or very small – so no one could see them. This is the first 'step' on the dissociative continuum (see below); avoidance. Adult often simply view these children as quiet, shy or 'slow.' Be present, patient and quiet when you engage these children. Over time they will feel safe enough to come to you.

2. Be prepared for misunderstandings and miscommunication. Even when they seem to understand your instructions, they may not be 'hearing' them the way you said them. There are times, of course, when it is important to give direction, re-direction, advice and commands to these children. Depending upon how sensitized they may be, the simple task of getting face to face to ask them simple questions or give simple commands "clear your place and put the dishes in the sink" will push them further down the dissociative continuum (see table below). In these situations, they will often look directly at you (studying your non-verbal cues) and act as if they are hearing, processing and ready to act on your instructions. Yet due to the inefficient processing that occurs when they are in this 'compliant' dissociative state, they may only carry out a portion of your request (e.g., they clear their place at the table but put their dishes on the counter and not in the sink). The older the child gets the more complex are our expectations and directions. Unfortunately, the dissociating child will still tune out and inefficiently process information. When confronted, they may even say, "You didn't say that." Remember that the child is not intentionally distorting or lying or manipulating. If they are dissociative, they will be physiologically incapable of efficient 'hearing'. Again, patience. Simple one-task commands are helpful. Written instructions can also help. Be prepared to communicate with an older child as if they are much younger.

3. Watch out for "false" compliance. It is easy to misinterpret their attentive and apparently, compliant interactions. As mentioned above, the processing of interactions is often slower, less efficient and distorting. When the child nods as if they understand you, ask them to repeat what they heard. Ensure that the child has fully understood what you are saying. Even then expect only 'partial' follow-through. Try to remember they are doing the best they can. They just process and interpret interactions differently than we do. Over time this will improve; especially if the misunderstandings and miscommunications don't lead to frustrated, angry and confused interactions which will keep the child dysregulated, disengaged and dissociated – basically incapable of learning or healing. Dissociation can lead to a vicious cycle of misunderstanding, confusion, frustration and then further withdrawal.

4. Take advantage of healthy forms of dissociation. There are many healthy ways to 'dissociate'. In fact, mind-wandering and daydreaming are very healthy forms of dissociation

and are related to creativity and memory consolidation. Reading, watching a film (or TV), drawing (and other creative arts), and, yes, even playing video games are all relatively healthy forms of dissociation. These can be very positive regulating tools for neurotypical and dissociating children. Children and youth who dissociate often have gravitated to one or more of these activities to self-regulate. A key to using these tools is moderation. By offering times and places for predictable and moderate 'doses' of these activities (e.g., 20-30 minutes of reading or video game 3 to 4 times a day) you can help the child slowly move from a 'sensitized' dissociative system to one that is more typically sensitive. Slowly begin to introduce other forms of healthy self-regulation – especially somatosensory – taking walks, dance, music. As the child begins to experience and master these alternate forms of regulation, the pressure to use 'deep' dissociation to regulate can ease.

5. Be prepared to repeat yourself – consider using visual aids for transitions, household chores and school work. Due to their processing inefficiencies and other 'head in the clouds' qualities these children need external supports for organization. Visual calendars, watches with alarms, notebooks with 'tasks' and check boxes – and a variety of other visual reminders can be helpful. In general, these children want to do well; by teaching them some of these organizational strategies you and the child will find more time for enjoyable interactions – which will be bonding - all of which can help with the healing process.

6. Anticipate that their sense of time can get distorted – leading to a whole set of problems. These children are often late, slow in transitions such as getting ready for school or finishing a task. One of the major areas of struggle is with math and other sequentially-mastered academic topics. It can be confusing how the same child who does well in English and gets A's can struggle with math and get D's. But this is common with these children. It is not because they are not trying. They just process differently; one on one tutoring can help. But the way we pay attention is not the way they pay attention; be ready to be frustrated. But remember – these children are extremely sensitive to emotional shifts; they sense and dissociate with the slightest hint of frustration or anger. Regulate, relate then reason.

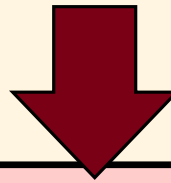
7. Cutting, picking, excessive scratching, head-banging and other odd or painful-appearing behaviors are often seen. Due to their 'sensitized' dissociative neurobiology, when they experience 'painful' input it causes an exaggerated release of their body's own painkiller – enkephalins and endorphins. This is rewarding and regulating for them. Many of these children have found that cutting, scratching until they bleed and other painful behaviors actually regulate them. They will use these maladaptive behaviors when they feel more distressed or overwhelmed. The best strategy to minimize these behaviors is to find replacement (e.g., video games) but healthier dissociative strategies and somatosensory regulation choices (e.g., rocking, walking, music).

8. Somatic 'symptoms' such as headaches, stomach-aches, light-headedness and even fainting are common. The changes in the stress response systems throughout the brain and

rest of the body will frequently result in real physical symptoms such as headaches and gastrointestinal problems such as constipation alternating with diarrhea – or just abdominal cramping. These are real symptoms and likely related to overly reactive opioid systems. Due to the low heart rate, a number of cardiovascular symptoms are also seen including light headedness or even fainting (called syncope). These symptoms should all be worked up by a physician but don't be surprised if the work up doesn't find anything. Another common issue is apparent seizures (staring spells). These are common and are usually not due to an actual seizure disorder (but again this needs to be evaluated); in the United Kingdom, this is called non-epileptic attack disorder (NEAD: see nonepilepticdisorderattackdisorder.org.uk). Don't be surprised if the doctor has not heard of this. These trauma-related problems are very slowly being integrated into mainstream medicine.

9. These children can also 'blow up'- different evocative cues can cause profound externalizing dysregulation. It is common for children with complex and pervasive histories of trauma to have BOTH a sensitized dissociative and arousal response. Different evocative cues (e.g., loud male voice, authority figures) will elicit the externalizing (i.e., hypervigilant, hyperactive, impulsive and aggressive) behaviors. The same child may find female evocative cues elicit 'dissociation' – and he will be compliant and apparently 'regulated' with the female staff or teacher but clearly dysregulated by the male staff/teacher. This results in a confusing and complex behavior picture. Remember that both of these response patterns can be addressed; and in all cases, a key is to stay as regulated as possible. This speaks to the ongoing need for self-care. **You can help regulate your dysregulated child ONLY if you stay regulated.** Take care of your needs. It is not selfish – it is essential if you are going to be a therapeutic presence for the child.

10. Fantasy play, drawing, reading, viewing and gaming can become extreme but don't use these activities in any "reward" or "punishment" model. Contingency based behavioral strategies dysregulate children, cannot build complex skills and are ineffective with these children. One of the major challenges in the 'trauma-sensitive' systems movement is that the most common and pervasive approach used in most schools and mental health systems with maltreated and traumatized children is traditional 'contingency' programs (points and levels with 'rewards' and 'consequences'). These approaches are effective for some basic behavior changes with neurotypical (and not dysregulated or sensitized children or youth). The unfortunate reality is that these approaches actually escalate and further dysregulate these children leading to increased rates of critical incidents such as run away or aggressive behaviors. It is common in a contingency approach to restrict the primary regulatory tools these children use as a source of regulation (e.g., sport, recess, video games). This is a mistake. It will not build internal motivation or lead to any meaningful change in the sensitivity of children who dissociate. It will drive them further into a disengaged, 'false' compliant state. What can look like 'progress' is often simply a hollow victory – the child has simply disengaged.



Hyperarousal Continuum	Rest (M > F: A>C)	Vigilance	Resistance	Defiance	Aggression
Dissociative Continuum	Rest (F > M: C>A)	Avoidance	Compliance	Dissociation	Fainting
Primary secondary Brain Areas	NEOCORTEX <i>Subcortex</i>	SUBCORTEX <i>Limbic</i>	LIMBIC <i>Midbrain</i>	MIDBRAIN <i>Brainstem</i>	BRAINSTEM <i>Autonomic</i>
Cognition	Abstract	Concrete	Emotional	Reactive	Reflexive
Mental State	CALM	ALERT	ALARM	FEAR	TERROR

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State-dependent adaptations to threat. Different children have different styles of adaptation to threat. Some children use a primary hyperarousal response some a primary dissociative response. Most use some combination of these two adaptive styles. In the fearful child, a defiant stance is often seen. This is typically interpreted as a willful and controlling child. Rather than understanding the behavior as related to fear, adults often respond to the 'oppositional' behavior by becoming angrier, more demanding. The child, over-reading the non-verbal cues of the frustrated and angry adult, feels more threatened and moves from alarm to fear to terror. These children may end up in a very primitive "mini-psychotic" regression or in a very combative state. The behavior of the child reflects their attempts to adapt and respond to a perceived (or misperceived) threat

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