

SECOND EDITION

DISSOCIATION IN TRAUMATIZED CHILDREN AND ADOLESCENTS

Theory and Clinical Interventions

EDITED BY SANDRA WIELAND

ROUTLEDGE

Dissociation in Traumatized Children and Adolescents

Dissociation in Traumatized Children and Adolescents presents a series of unique and compelling case studies written by some of the foremost international experts in the study of dissociation in young people. In the new edition, chapters have been updated to include discussion of the most recent findings in trauma and neuroscience as well as Joyanna Silberg's popular affect avoidance model. In addition, Sandra Wieland's incisive commentaries on each case study have been updated. Each chapter presents a detailed narrative of a therapist's work with a child or adolescent interspersed with the therapist's own thought process, and every therapist explains the theory and research behind her clinical decisions. The case studies present many aspects of working with traumatized children—attachment work, trauma processing, work with the family, interactions with the community, psychoeducation related to dissociation, and encouragement of communication between the dissociated parts—and provide a frank analysis of the difficulties clinicians encounter in various therapeutic situations. While the book is exceptional in its clear and detailed descriptions of theory related to dissociation in children, most importantly, it illustrates how theory can be translated into successful therapeutic interactions.

Sandra Wieland, PhD, is a clinical psychologist, certified play therapist, and consultant in Victoria, Canada. She was the founding director of the Centre for Treatment of Sexual Abuse and Childhood Trauma in Ottawa and has also worked as an adjunct clinical professor at the University of Ottawa.

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Second Edition

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Sandra Wieland

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Foreword

Richard P. Kluft, MD, PhD

When we begin to work with a condition or with a group of patients who are unfamiliar to us, we turn to the literature, take courses, and consult with colleagues more experienced than ourselves for guidance. We look to those who have already encountered those conditions and types of patients, veterans who have actually been there, experienced hands who have helped their own patients traverse the hazards of these psychological landscapes and navigate their journeys of recovery. Lacking our own experiential encyclopedias, we look elsewhere for models, approaches, and advice to protect both our patients and ourselves from the potential adverse consequences of our learning on the job, engaging in a risky and dubious process of trial and error.

Yet, we cannot turn to such resources until they have been developed. The modern history of the diagnosis and treatment of dissociative disorders in children and younger adolescents begins only about a quarter of a century ago, and did not progress as rapidly as work with dissociative adults. All the more reason to celebrate Sandra Wieland and her colleagues' contributions to *Dissociation in Traumatized Children and Adolescents: Theory and Clinical Interventions*, who share a wealth of clinical experience and wisdom as they allow us to bear witness to their clinical endeavors. We follow their therapeutic efforts and their reflections upon their work with youngsters suffering profound dissociative psychopathology. Their accomplishment is no less than bringing the treatment of dissociative children and adolescents to life, providing us with a depth of understanding and hard-won clinical wisdom available nowhere else in the literature; and offering us insights that would take an individual practitioner years to acquire on his or her own. Wieland's theoretical analyses of the case studies themselves help the reader situate the contributors' clinical work within the framework of a number of contemporary paradigms of dissociation.

It is easy to forget that even though the first successful psychotherapeutic cure of dissociative identity disorder (DID) involved Despine's treatment of his 12-year-old patient, Estelle, in the 1830s (Ellenberger, 1970), it would be almost 150 years before such youthful patients would once again be the subjects of detailed discussion in the professional literature.

When I began to identify and work with DID patients in the early 1970s, I rapidly began to contemplate the importance of identifying and studying childhood cases for both understanding DID and for establishing the legitimacy of the condition. Almost from the moment I began to work with DID, I was assailed with accusations that I had iatrogenically created the DID cases I was treating. As I reflected upon the vehemence with which I was attacked, I, too, was impressed, in an era before the phenomenology of DID was well understood and before sophisticated diagnostic strategies had developed, that when DID symptoms often seemed to appear out of a clear blue sky, it was easy to understand why skeptics would suspect something was amiss. Where had the DID come from? One day a person seemed to have anxiety, depression, or both, and the next day that person was being rediagnosed with DID. Pioneers in the field became accustomed to hearing, "Yeah, they come to you and suddenly they have DID. All your patients have DID because you created it!"

Such concerns were among the factors that motivated some of my own research. By studying a cohort of DID patients over several years, I was able to describe the natural history of DID, demonstrating its generally covert nature and intermittent overtness (Kluft, 1985). A major aspect of that effort was the quest to identify DID both in childhood and in the elderly. If DID or DID precursors could not be identified in the young, how could we assert that it was highly associated with the traumatization of the young instead of deleterious influences within the treatments of adult patients? If DID did not exist in older-age cohorts who came to maturity before DID became a condition widely discussed in the media, that would argue that DID either was not naturalistic or that it burned out with age. Also, since DID patients so often lead difficult and tormented lives devastated by this disorder, the early identification and treatment of their DID might hold the potential to reduce their years of suffering and offer them more gratifying and successful lives.

Although I asked colleagues to allow me to assess any youngsters they suspected might have some dissociative difficulties, no subjects were referred through such channels. Among the projects I was able to undertake within the context of my private practice was to periodically screen, at no expense, a particular group of vulnerable children to see if any developed DID. This sample of convenience consisted of the young children of recurrently hospitalized women with DID who had entered my practice. Two years passed without my locating a single case. Then, in the late 1970s, one of my DID patients, successfully integrated and looking at the world with new and unflinching eyes, began to tell me that she thought her son suffered from DID. She was a high-functioning DID patient; I had not considered screening her children. I was quite skeptical. It took her several months to persuade me to assess this boy. In retrospect, I suppose I was somewhat condescending, perhaps thinking, "How on earth could this woman make an accurate diagnosis of DID in a child? Is she projecting

her own issues onto her son?" To my utter astonishment, I found myself sitting with "the real deal," an 8-year-old boy with classic DID symptoms and a witnessed history of two major childhood traumata, a near drowning and physical abuse by his father. Within weeks of discovering this index child with DID, I was able to diagnose DID in one of the children I was following, another 8-year-old boy had been recently beaten by an out of control alter of his DID mother. Having been humbled once, when the mother of my first child with DID returned from a visit to her mother a few months later, after years of estrangement, and told me that she suspected that her 82-year-old mother suffered from DID as well, I immediately set up an evaluation. Her mother indeed suffered from DID, but her alters rarely emerged any more, having shifted into one alter predominant mode, which I soon would appreciate was typical of older DID patients. Within a matter of months, one astute woman had provided me an entrée into the study of DID in both childhood and old age, completing the circle for my efforts to characterize the natural history of DID (Kluft, 1985)! I and the entire field owe her a debt of gratitude. I had the pleasure of introducing her to the late Cornelia Wilbur, M.D., who was delighted to meet this important, albeit anonymous, contributor to our knowledge of DID.

With the discovery of these two boys, I was able to begin the study and treatment of childhood DID. I mentioned the successful integration of one of these boys in an article on treatment in 1982, and offered a summary of what I had learned from these and other cases in further publications (Kluft, 1984, 1985). In my eagerness to demonstrate the existence of childhood DID, I did not think to describe cases in which only precursors, formes frustes, or marginally diagnosable phenomena were present. Fortunately, that same year Fagan and McMahon (1984) published their own classic paper on "incipient multiple personality disorder," covering this important and easily overlooked population.

Thereafter, a number of helpful papers began to fill in our picture of dissociative disorders in childhood and adolescence. In 1996, Joyanna Silberg edited the landmark first edition of *The Dissociative Child*, marking a major leap forward in raising the mental health professions' awareness of childhood dissociative disorders and providing a powerful resource for clinicians and scholars. Much more could be said about this march of progress, but this is not the place for a more comprehensive review.

It is interesting to reflect upon the differences between the treatments described in this volume and those that I and others conducted in the late 1970s and the early to mid-1980s. I was focused on demonstrating the existence of DID in children. My series consisted of children who fulfilled the demanding diagnostic criteria of *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised (*DSM-III-R*) (American Psychiatric Association, 2000). This restricted me to cases with at least one fully developed and elaborately different alter, as would be required to diagnose

DID in an adult. In contrast, the series of children and adolescents reported by Wieland and her collaborators represent a wider spectrum of dissociative psychopathology. They were identified after the *DSM-III* criterion of demonstrating elaborated differences had been rescinded. In addition, consistent with the findings that emerged from establishing the natural history of DID (Kluft, 1985), they reflect the realizations that: (1) more dissociative patients merit the diagnosis of dissociative disorder not elsewhere classified (DDNEC) than qualify for the diagnosis of DID; and (2) that most patients with DID spent most of their lives showing subsyndromal psychopathology, appearing to have DDNEC, a few dissociative manifestations, or even no dissociative manifestations at all for prolonged periods of time.

In the earlier cases, attachment was an issue, but proved to be a compelling concern in only one case. The current text regards attachment as a central ubiquitous organizing paradigm. In the earlier series, however, the identification and treatment of trauma played a much more central role, and was the predominant area of concern. Therefore, the contrasts in emphasis between the contemporary and the older case reports are so dramatic that, at times, the reader might come away with the erroneous impression that the more modern contributors are according trauma a minor role in the etiology of these dissociative disorders, and giving the processing of trauma a minor role in their treatments. In fact, the contemporary contributors are prioritizing the description of those aspects of the treatment they assume will be less familiar and more important to communicate to the reader.

Also, between the treatment of the earlier series and the therapy of the current series, conflicts over the vicissitudes of human memory have been prominent in the both the media and the scientific literature. In that connection, many contemporary clinicians have backed away from techniques that had already demonstrated their helpfulness in the earlier series, but that had come under attack over the intervening years.

In the earlier series, the young patients' abusers were readily identified, often by their own confessions, or suspicion and evidence pointed strongly to a particular suspect, and the children could be protected from confirmed or suspected abusers in short order. In the current series, at times it is not clear how rapidly abusers have been identified, and sometimes their identities are unknown. In the older series, acquired in a conservative "law and order" environment in which authorities responded aggressively, abusers or suspected abusers were either removed from contact with the child, or investigated vigorously by the appropriate authorities, facilitating the rapid establishment of safety. In most instances, authorities insisted that therapy continue until they were convinced that the child was well, and the home environment was deemed safe. In contrast, in the contemporary series, clarity was less easy to come by, and therapists were confronted with circumstances less supportive of their efforts. In fact,

caretakers interrupted a number of the treatments, an event that occurred only once in the earlier series. It has been more difficult for the more modern therapists to establish and protect the treatment frame.

In the older cases, treatment often was brief, and hypnosis played a significant role. In the current series, heterohypnosis has not appeared to be a major modality, and the treatments are much more prolonged.

It might be assumed that these differences reflect growth and progress in the field. To a considerable extent, they do. To a certain extent, they may reflect differences in the two samples. However, when we consider that all three of the five young patients described in Kluft (1984) who are still under sequential observation have maintained their integrations for over a quarter of a century, it suggests that these older approaches may continue to have much to offer, and that future clinicians, less traumatized by the terrible "memory wars" of the 1990s, will move toward a fruitful synthesis of the models described in both the current and the older literature.

Any clinician interested in the treatment of trauma and dissociative disorders will find the collection of cases in *Dissociation in Traumatized Children and Adolescents: Theory and Clinical Interventions* richly rewarding and informative, and those with special interest in the treatment of children and adolescents with dissociative disorders should regard this book as required reading. *Dissociation in Traumatized Children and Adolescents: Theory and Clinical Interventions* belongs on the bookshelf of every clinician who treats or who anticipates treating dissociative children and adolescents, and it should be read by every researcher studying trauma, dissociation, and dissociative disorders in the young.

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About the Editor

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About the Contributors

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Introduction

As I began preparations for teaching my second course (2008) on Assessment and Treatment of Children and Adolescents with Complex Trauma/Dissociation, a course sponsored by the International Society for the Study of Dissociation and Trauma, I thought, "Wonderful, we are doubling the number of child therapists in western British Columbia trained in childhood dissociation." My second thought was, "That's pitiful—first going from 15 to 30." Now it is up to 60 and, in another year, it should be up to 90—that is still pitiful. That was 90 out of several thousand child therapists in Canada.

Each year since then, this specialized course on children and adolescents with complex trauma and dissociation has been offered in a variety of countries, including England, Canada, the United States, the Netherlands, Sweden, and Germany, and is being prepared for Argentina. The course has also been offered online over the past three years (see www.isst-d.org/training). In addition, there are many other training opportunities in trauma and child dissociation happening across the globe. But still, the number of child therapists *trained* in trauma and dissociation is in the hundreds, while the number of therapists *working* with children and adolescents who have experience of trauma and dissociation is in the thousands, and probably the hundreds of thousands.

The first edition of *Dissociation in Traumatized Children and Adolescents: Theory and Clinical Interventions* (2011) was written as a way to spread training to therapists who were not able to attend special workshop days. The book was designed to capture what had been most helpful in the face-to-face teaching—the case examples: the telling about what actually happened in the therapy room between me and the child or the adolescent, and the telling about my own thoughts as I did the clinical work. Understanding dissociation—what it is, why it happens, what it looks like—was helpful and certainly necessary. But to be ready to go into the therapy room and work with these children and adolescents, one needs to "see" the therapeutic dynamics. It was from that initial internal conversation in 2008—my discouraged self-state debating with my problem-solving self-state—that the first edition of *Dissociation in Traumatized Children and*

Adolescents emerged—a book that not only could educate therapists about dissociation, but also could provide glimpses into therapy sessions and into the thoughts of the therapists.

Over the last four years, since the first edition came out, therapists and parents both here in Canada and abroad have told me how much the book helped them in their understanding not only of children who had been traumatized, but also of the therapy that can help these children. During that time, further research related to the effects of trauma on children has been published and a new model of dissociation—the affect avoidance model (Silberg, 2013)—has been presented. This model is unique and extremely valuable in that it was developed by a therapist who works exclusively with children and adolescents—Dr. Joyanna Silberg. Silberg did not approach the topic of dissociation from a theoretical perspective but, rather, from a very practical perspective—what is it that the child is doing (neurologically/behaviorally) that caused this "movement away"/dissociation to occur. The second edition of *Dissociation in Traumatized Children and Adolescents: Theory and Clinical Interventions* provides a valuable update to the first edition.

The first case description of a child who was clearly dissociative (multiple personality disorder in childhood) was of an 11-year-old girl whose treatment (hypnotherapy) was described in 1840 by Despine (Trans. McKeown and Fine, 2008). Unfortunately, the field of child mental health did not pay attention to this case and, because (as discussed in Chapter 1) child dissociation can look the same as other child diagnoses, further discussion of childhood dissociation did not appear for another 140 years. In the 1970s, Dr. Richard Kluft, one of the early pioneers in recognizing and treating dissociation, started looking for cases of childhood dissociation. He believed that if the then prominent accusation that dissociated states were a creation of a therapist and not an internal reality of the distressed individual was to be successfully refuted, then the existence of dissociation in children following trauma needed to be identified (Kluft, personal communication, 2010). And, of course, the cases were there. Although the therapy proved to be shorter and simpler than treatment for adults, there were clear similarities in that both the trauma and the dissociated states needed to be addressed. In 1984, Kluft published a description of five childhood cases of multiple personality disorder (Kluft, 1984), and Fagan and McMahon (1984) published a description of four children with "incipient multiple personality disorder" (now known as *dissociative disorder not elsewhere classified* (DDNEC)). Both of these articles stressed the importance of working with the family and increasing the child's sense of safety, together with the work related to dissociative episodes and early trauma. Over the next twenty-five years, numerous articles and a few books were published describing case studies, symptoms, diagnostic checklists, and models of dissociation, as well as research

related to the incidence of dissociation in particular child and adolescent populations (reviewed in Silberg and Dallam, 2009).

During the 1980s, most of the therapists treating dissociative children were coming to this work from their experience with adults (Drs. Polly McMahon and Gary Peterson being noted exceptions). Toward the end of the decade, child therapists started noticing and learning about dissociation. As Joy Silberg (Baltimore, Maryland) described in her book, *The Dissociative Child: Diagnosis, Treatment, and Management* (1996), when she first learned about dissociation, she started to wonder—if dissociation came from childhood abuse, then surely, dissociation would be there in many of the children who had been abused. In Marquette, Michigan, Fran Waters heard a presentation on assessing multiple personality disorder (MPD) in adults and decided to ask an 8-year-old child with whom she was working—who was not getting better despite an excellent therapy program—if she was hearing voices. Not only did the child respond in the affirmative, but she was willing to draw a picture of the voices inside her head. About this same time, I was working in the children's outpatient department at the psychiatric hospital in Ottawa, Canada. Dr. George Fraser (1993, 2003), who was working with dissociative (referred to at that time as multiple personality disorder) clients in the adult outpatient department, called me up and asked me if I would see the 4-year-old daughter of one of his MPD clients. Thanks to Dr. Fraser, I now had a term that I could use to describe the contradictions I observed in this child's presentation, drawings, and play—dissociation. These were contradictions that I had been noticing in many of the children I had been seeing.

Clinicians working mostly with adults but also with some children who dissociated were gathering together to share cases and theories. In 1983, a fledgling society called the International Society for the Study of Multiple Personality and Dissociation (ISSMPandD) held its first conference in Chicago, Illinois (Kluft, 2003). As this society (now known as the International Society for the Study of Trauma and Dissociation—ISSTD) grew and increasing attention was given to both the development and the treatment of dissociation in children, a Child and Adolescent Committee was formed in the late 1990s with the mandate to develop research, writing, and teaching in the area of childhood dissociation. In 2004, the Child and Adolescent Committee published the "Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents." These are available on the ISSTD website (www.isst-d.org). In 2006, a syllabus for a course on Assessment and Treatment of Complex Trauma/Dissociation in Children and Adolescents was completed, and this course is now being taught internationally. In 2008 and 2009, the Child and Adolescent Committee developed sets of frequently asked questions (FAQs) and answers both for parents and for teachers. These are available on the ISSTD website.

This book, presenting both theory and clinical cases, reaches beyond the guidelines and FAQs to give therapists a view into the actual process of therapy with children and adolescents who dissociate—how they present, what they need, and how they heal.

The book begins with a chapter describing dissociation in children—why dissociation occurs, how it may manifest itself, and the many varied symptoms. Although our understanding of the neurological mechanisms underlying dissociation is still limited, they are important to consider and are described. Five conceptual models of dissociation are then presented followed by six clinical studies. The authors are all members of the Child and Adolescent Committee of the ISSTD. They work in different countries—Argentina, Canada, England, and the United States—and have practiced in a variety of settings, including psychiatric hospitals (inpatient and outpatient), clinics specializing in working with trauma, social service agencies, schools, and private practice.

The clinical studies can be read individually or in sequence. Each is unique. The children come from different family situations: foster family (Dalma), adoptive family (Jason), relative adoptive family (Joey), relative home (Leroy), and birth family (Ryan, and Angela). All names are changed to protect confidentiality.

The traumas experienced are different: early neglect (Dalma, Jason), sexual abuse (Dalma, Jason, Ryan, and Angela), physical abuse (Jason), witnessing domestic violence (Jason, Joey), loss of primary attachment figure (Joey), painful medical conditions (Ryan and Angela), and unknown (Leroy).

The age at time of treatment differs (4 to 16 years of age). The therapy formats differ: two-week intensive therapy (Jason), two-year intermittent therapy (Angela), extended weekly therapy (Dalma, Ryan, and Joey), and school intervention without psychotherapy (Leroy).

In the first clinical study, Baita describes a child she met early in her work with dissociative children. Not only did she have limited training and experience in the area of dissociation, but there was also limited literature and collegial support available. For therapists who are new to the field of dissociation, the experiences of this therapist will be of considerable interest. The other therapists present children they saw after many years of working in this field. However, as you will discover as you read their stories (and as you work with your own clients), new situations and dilemmas are not reserved for inexperienced therapists, they happen all the time.

The children's diagnoses are not uniform. Baita, Marks, and Waters present children who are diagnosed as having dissociative identity disorder (DID). Wieland and Silberg each describe a child/adolescent with dissociative disorder not elsewhere classified (DDNEC).

Even though the cases are different, there are many similarities among them. Each therapist is keenly aware of the importance of the child

experiencing a sense of safety and stability, of creating or strengthening a secure attachment pattern, and of helping the child develop calming (emotional regulation) within his or her neurological and physiological system. The role of psycho-education as integral to the therapy, the importance of being aware of all parts or self-states, the need to increase internal communication between parts, and the role of processing trauma experiences are addressed in each clinical study.

The therapists share their thoughts related to dissociation and what they understand regarding the dynamics occurring for the child. Perhaps most importantly, they note where they became distracted or confused in their work—we all do—and their thoughts after the session. The therapists provide you with references for further reading in the areas of dissociation and therapy with children. Following each clinical study, you will find a short commentary highlighting some of the issues presented by the child or adolescent, particular types of interventions used, and how understanding neurological effects related to trauma, as well as the conceptual models of dissociation described in Chapter 1, may have helped to inform the therapist. When you are working with a particular child in your practice, you may find these commentaries helpful for knowing which case study will be most helpful to reread for ideas and reassurance.

Most of us, when first learning about dissociation, thought as Frances Waters describes: "I would perhaps only see one in my lifetime" (personal communication, 2009). Since then, each of us has assessed and treated numerous children and adolescents with dissociation. For some of us, this number is in the hundreds. We now invite you—therapist, doctor, occupational therapist, speech and language pathologist, social worker, teacher, parent, whatever role you have with children who have been traumatized—to join us in learning more about these children and how to help them.

I am grateful to the Child and Adolescent Committee of the ISSTD for taking on this task and for bearing with me as I have nagged them over the years leading up to the first edition, later for a translated edition, and now for the second edition. Special thanks go to Margaret Stephens, my colleague and friend, who debated ideas, read the manuscript, and generally cheered me on. To Chris Whelan, thank you for your patience and all your assistance. And from each of the contributor-therapists, thank you to the children and adolescents with whom we have worked. Thank you for trusting us with your experiences and for teaching us what you needed.

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1 Dissociation in Children and Adolescents

What It Is, How It Presents, and How We Can Understand It

Sandra Wieland

Children and infants threatened by extreme situations, be it neglect, intrusion to the body, or surrounding danger, seek to keep themselves safe—to keep themselves away from what is happening. Physically, the infant or child cannot get away. Psychologically, they can.

Dissociation provides a way to survive overwhelming and, in particular, repetitive fright. The infant or child may move mentally "into" the teddy bear on the shelf, or up to the corner of the room and from there observe what is happening to the body "left behind." The infant or child may stay present in her body but cut off all emotional or physical feelings. By placing this space or barrier between her and the danger, the infant or child's distress and anxiety decrease. As with anything that relieves intense distress, this process of successful separation (dissociation) will be repeated when danger reappears. In time, this movement away may become a regular pattern of reacting to frightening or emotionally destabilizing situations.

Dissociation may occur from time to time as a normal phenomenon for both children and adults. For children and adults who are abused, neglected, or terrorized in some way, dissociation becomes a protective mechanism and may be repeated over and over again (Kluft, 1985; Putnam, 1997; Saxe et al., 1993; Silberg, 2013). Although protective, this distortion of perception and of cognitive integration causes the child to lose touch with a part of her feelings, physical sensations, knowledge of what has happened and, thus, with a part of her experience of self. Although unavailable to the child's integrated awareness (i.e., consciousness), these feelings, physical sensations, needs, memories, and parts of self continue to exist, only separated off, within the individual's internal world. The child's internal working model of self is fragmented (Liotti, 2009; Wieland, 1998). Therapists working with children and adolescents who have experienced extreme fright need to understand the phenomenon of self-fragmentation—the phenomenon of dissociation.

This chapter describes the difference between normal dissociation and dysfunctional dissociation in children and adolescents, and varying levels

of dysfunctional dissociation. We will consider why some children dissociate while others who experience a similar or seemingly more extreme trauma do not. Symptoms of dissociation will be described. Although our understanding of the neurological factors underlying dissociation is limited, the known effects of childhood trauma on brain development, and thus likely playing a role in dissociative functioning, will be described. We will then turn to conceptual models of dissociation to assist our understanding and to help us formulate therapeutic guidelines. Five models of dissociation will be presented with a discussion of how the theories underlying the models can be helpful for the therapist working with a child or adolescent who experiences dissociation. The last part of the chapter will introduce the case studies to follow. These case studies will provide the reader with a glimpse into the intimate experience of therapy together with the therapists' struggles to understand what is happening and where to go next in their work.

From Normal Dissociation to Dysfunctional Dissociation

Dissociation, the absence of awareness of what one is doing or what is going on around one, is a normal process that occurs from time to time. Fantasy stories and characters created by the preschool child often take on a separate reality. Imaginary playmates may be an enjoyable fantasy, an expansion of experience, a way to fill loneliness or boredom, or a process for working out fears and ambivalent feelings (Baum, 1978; Trujillo et al., 1996). When a child plays a video game, he may become so involved with the game that he becomes unaware of the world or others speaking to him. Adults may experience a similar type of dissociation when they are reading or driving but their minds are totally involved with other thoughts. On arrival at the bottom of the page or set destination, the individual realizes he has no idea of the words read or the path he took to arrive at that location. This type of experience is more likely to happen when the individual is under considerable stress—the stress demands, both emotional and cognitive, take over the individual's active awareness (consciousness).

Children and adults may experience a depersonalization experience —seeing or experiencing themselves as if from the outside—when they are caught in a frightening situation (e.g., being bitten by a dog, being in a car accident), or are going through a particularly stressful time. In a study of university students (Dixon, 1963), almost half of the students reported having had a depersonalization experience at some time while growing up. Putnam (1997) noted that transient episodes of depersonalization appear relatively common for adolescents. These episodes decrease with age.

Dissociative experiences that are part of normal development do not cause a fragmentation of experiences or self. The child can be aware of what has happened and can talk to others about what has happened.

The fantasy world or the survival of a car accident becomes part of the child's story and, thus, a part of a single sense of self.

If, however, a child's experience continues to be either frightening or non-supported (no soothing or opportunity to process the upsetting situations that have happened), dissociative experiences are likely to continue. As dissociation continues, more and more of the child's perceptions, feelings, physical sensations, or knowledge of the world become stored outside active awareness and the child's internal sense of self becomes disrupted. The perceptions, feelings, and knowledge are still there—they have, after all, been sensed and processed in some form by both the brain and the body—but they are shut out of active awareness. Because this "shut-out" or dissociation protects the child from negative situations, the child is less likely to develop coping mechanisms that do not damage the sense of self. Consistent learning and the building of consistent friendships are difficult for the child. If there is no intervention from supportive, consistent care-giving or therapy, this fragmentation is highly likely to continue and, in many situations, increase as the child grows up.

Up to this point, we have been talking about dissociation on a continuum—from normal to dysfunctional (Allen, 2001) with an increasing intensity of dissociative functioning (see sections below: "Mild Dissociation," "Moderate Dissociation," "Extreme Dissociation"). Similar, but separate from the concept of a continuum, is the diagnosis of a *dissociative disorder* (including four sub-categories: *depersonalization-derealization disorder*, *dissociative amnesia*, *dissociative disorder not elsewhere classified*, *dissociative identity disorder*) or the diagnosis of *posttraumatic stress disorder with dissociative symptoms*, as described by the Diagnostic and Statistical Manual-V (DSM-V) (American Psychiatric Association, 2013). These diagnoses would be applied to the experiences at the dysfunctional end of the continuum and will be described further under moderate and extreme dissociation in the section below ("Extreme Dissociation").

Dissociation that has become problematic seldom occurs by itself. As noted, it may be part of a posttraumatic stress disorder (see the discussion "Why Does Dissociation Happen?" later in this chapter), part of childhood depression, or severe anxiety. Because of similar symptoms, it may look similar to, but is separate from, an attention deficit hyperactivity disorder (ADHD), an oppositional defiant disorder, a conduct disorder, a reactive attachment disorder, a bipolar disorder. Dissociation may, however, be comorbid with one or several of these disorders. The dissociation experienced by a child may be mild, moderate, or extreme (ISSTD, 2008).

Mild Dissociation

Mild dissociation presents as a type of "spacing out." This "spacing out" is different than the lethargy of a child with depression, or the withdrawal

of a child with anxiety. A child with depression may have little energy to attend to what is going on around him but knows that things are going on. A child with anxiety will find it difficult to focus thinking on what is going on but realizes that things are going on. Dissociative "spacing out" occurs both with and without intention and often without the child even realizing that it is happening. There is little or no awareness that the world around is continuing.

Abrupt changes in emotion or behavior may occur with mild dissociation. Most children who become upset experience a building of distress or other negative feeling to a point where the child no longer has complete control over his behavior. The child with mild dissociation is more akin to an infant or young toddler who moves directly to extreme states of reacting: the mid-states of moderate emotion are missing or minimal. Mild dissociation does not meet the criteria for any of the DSM-V (American Psychiatric Association, 2013) Dissociative Disorder diagnoses and, therefore, often are unlabeled by mental health professionals. If, however, the dissociation is not addressed within the therapy that the child receives, the distress experienced by the child seldom is remediated (Wieland and Silberg, 2013).

Moderate Dissociation

A child with moderate dissociation may experience a numbing of emotions or body sensations. This child is able to block out frightening experiences, strong emotions, body states, emotional needs, and even severe pain. As a result of this blocking, the child often responds to situations in what appears to others to be a bizarre manner—laughing when someone is hurt, or angry when things have gone well. The child may have the sense of being outside himself and, at the same time, observing himself within the situation. This is referred to as "depersonalization." The child may have the feeling that a situation is not really happening, that his surroundings or events are unreal. This is referred to as "derealization."

Depersonalization or derealization usually first occurs during a frightening event, and it may then reoccur whenever something in the child's world is similar in some way to the frightening event. As a new situation reminds the child of the original experience, usually at the unconscious level, the original fright response is likely to be triggered. And as the fright response is triggered, so also is the protective response of dissociation. The use of depersonalization or derealization to avoid distress is reinforced.

Another possible effect of dissociation is amnesia. Initially, this may occur for the frightening event but may, in time, extend to other situations or people that are similar in some way to that event. Some children may lose conscious awareness of small or large chunks of time.

If the dissociative symptoms are recognized, the child or adolescent may be diagnosed, based on DSM-V (American Psychiatric Association, 2013),

with Depersonalization/Derealization Disorder, Dissociative Amnesia, Other Specified Dissociative Disorder, or Unspecified Dissociative Disorder. Unfortunately, these children are often misdiagnosed with Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, or Bipolar Disorder. As noted, if the dissociation is not specifically addressed, the efficacy of the therapy is limited.

Extreme Dissociation

Extreme dissociation occurs when, in order to feel safe, the child needs to separate the emotions, physical sensation, or experiences so completely from his awareness that the child, outside of conscious awareness, "creates" separate parts of himself to hold these emotions, sensations, or experiences. These are referred to as dissociative parts or dissociative self-states. The child may experience these parts or self-states as voices telling him what to do, or as an 'outside' force making the child do something the child would not normally want to do. The child may find that he is suddenly consumed with the emotion or sensation from an earlier frightening experience or, indeed, re-experiences the age he was at the time of the initial trauma. The difficulty is that, while in a dissociative state, the child may be unaware of all the other learning and experiences the child has in his life. The child may be unaware that years have passed and that he is now in a safe place. Fear may be experienced without any moderation from the more recent experiences of safety in the child's life. Anger may be experienced without any moderation from the positive and supportive events that may have happened. Feelings of loss and loneliness would be experienced without any moderation from the supports the child currently has available.

What the child does when in a dissociated state will not necessarily be remembered when the child is not in that state. Each state—the emotion state, the younger child state, the "now state"—is likely to have a partially separate memory with limited recall across states. This is a more extreme form of dissociative amnesia—amnesia between parts of the self—than that discussed above. There does, however, continue to be an awareness within the child that there are other states or ways of feeling or being. The diagnostic term for this level of dissociation is *dissociative disorder not elsewhere classified* (American Psychiatric Association, 2013). This is a rather confusing label that has been chosen by the American Psychiatric Association for their Diagnostic and Statistical Manual because there is not, presently, a diagnostic label or classification for this level of dissociation. It applies to children or adults whose dissociation has moved beyond experiences of depersonalization, derealization, or amnesia to an experience of different parts of self. The angry or deprived feeling state of the child may steal or break things but later, when in another state (perhaps the part of the child who feels close to others), the child may or may not

have access to the memory of doing this behavior. He would, however, have an awareness that there is an angry or deprived part of himself. This child is often accused by parents, teachers, and friends of lying and acting irrationally, while the child not having an active memory of the behavior feels misunderstood and mistreated. This negative response from caregivers, together with the intense emotions associated with feeling mistreated, will often end up intensifying the child's use of dissociation.

For this dissociative child, new situations and new information gained by one part are not necessarily experienced or even passed to any of the other parts. Thus, the frightened infant or toddler part (experiences, sensations, affects) is not modified by later positive experiences during childhood and adolescence. For some children, there may be numerous different parts within each age group. For example, one part may hold the anger so another part can be loving; one part may hold the fear so another part can be adventuresome.

The most extreme form of dissociation occurs if these dissociated states or parts *take over* the child's functioning, as opposed to functioning *through* the child. Because the child's facial expression, movements, and general demeanor can greatly vary from one state to the next, the child appears as if he is almost separate people. The child does not have recognition when in one state or part that other states or parts exist. Without this awareness, the child has little or no control over which part is presenting at any particular moment. The switches between parts tend to be very sudden and often without the child or the people around the child being able to recognize what triggered the switch. This is referred to as *dissociative identity disorder* (DID) (American Psychiatric Association, 2013). The child may or may not give specific names or other defining attributes (age, gender, feelings) to these parts.

Why Does Dissociation Happen?

Dissociation is a way of keeping overwhelming events, feelings, sensations, and thoughts away from the self. Direct violence (sexual abuse; physical abuse), or witnessing violence to another person (particularly if the person is within the family), or to an animal can be overwhelming. Verbal abuse by parents or by peers (particularly during the mid-school years) has been found to be a significant precursor of dissociation (Teicher et al., 2010). Loss of a parental figure (through death, serious illness, mental disorder, neglect), or frightening behavior on the part of the parent can overwhelm a child's ability to maintain a coherent self. Frightening or very painful medical conditions or procedures, as well as frightening natural disasters, can lead to dissociation.

Dissociation is frequently referred to as "trauma-induced." It is, however, more than that. When a single overwhelming trauma occurs, a child or adult normally responds with a posttraumatic stress disorder (PTSD).

Individuals with PTSD present with four different types of symptoms: (1) intrusion of the trauma experience into present functioning (for a child this may be reenactment through play or drawings), (2) avoidance of any reminder of the trauma, (3) negative alterations in thought and mood, (4) changes in levels of arousal and reactivity (American Psychiatric Association, 2013). While the majority of individuals experiencing PTSD show high reactivity, there is a subgroup of children and adults whose behavior fits into each of these symptom groups but has a quality of detachment as opposed to high reactivity (Lanius et al., 2013). This group of individuals is referred to as a dissociative subtype of PTSD (American Psychiatric Association, 2013; Lanius et al., 2013).

Although dissociation and PTSD may coexist (as in the dissociative subtype of PTSD) and are both an outcome of trauma, they are not synonymous (Lanius et al., 2013; Simeon, 2007). Simeon, using behavioral, cognitive, and neurological studies, examined four possible relationships between PTSD and dissociation: comorbidity, shared risk factors, shared pathogenesis, or same disorder. Although there are shared risk factors, early onset of trauma is particularly relevant for extreme dissociation but not extreme PTSD. Attachment problems (referred to as "relational trauma," see the discussion related to disorganized attachment on p. 22) are very relevant in the development of dissociation but are not necessary for the development of PTSD. Difficulties in the area of memory and cognitive flexibility are strongly related to PTSD, while absorption and forgetfulness together with poor registration and expression of emotions are strongly related to the varying levels of dissociation. Simple PTSD is characterized by intrusion and arousal with minimal dissociation, while individuals with mild and possibly moderate dissociative symptoms may not exhibit other PTSD symptoms. The overlap appears to come with complex trauma (repeated or severe trauma without any access to soothing or processing), leading to both complex PTSD and more extreme dissociation as comorbid conditions (as reviewed in Simeon, 2007).

Scaer (2005) described PTSD as an extreme response of the sympathetic branch of the autonomic nervous system followed by an extreme parasympathetic response. With complex trauma, the shift from sympathetic hyperarousal to parasympathetic hypoarousal/dissociation becomes more immediate with the individual spending longer periods in dissociation (Scaer, 2005; Schore, 2009, 2012). Thus, PTSD and dissociation are often —but not necessarily—comorbid. They share risk factors with disruption of the attachment pattern being more relevant in dissociation. They share initial pathogenesis but, over time, demonstrate psychobiological differences.

Neuroimaging has shown strikingly different brain response patterns between individuals with simple PTSD and individuals with the dissociative subtype-PTSD or dissociation (Lanius et al., 2013). Individuals with simple PTSD show decreased activity in the area of the brain related to

problem-solving (medial prefrontal cortex (PFC) and anterior cingulate cortex (ACC)). It is this area of the brain that has extensive neuronal connections with the limbic system and thus provides a control mechanism for the fear/anger center of the brain (amygdala). As a result, when activity in the PFC and the ACC decreases, fear and/or anger spiral out of control (Frewin and Lanius, 2006). The ability to think clearly decreases. Individuals with dissociation, when faced with a reminder of a trauma, showed increased activity in the PFC and the ACC. This, in turn, means increased control over the fear/anger center of the brain (amygdala). For these individuals, fear and/or anger may close down and they become non-emotional (detached) even though they are faced with situations or reminders of frightening events—clearly a dissociative mechanism.

Research over the last decade has looked at a group of children experiencing significant difficulties related to affective and physiological dysregulation, attentional and behavioral dysregulation, and self and relational dysregulation for whom PTSD, dissociative disorders, or other diagnoses recognized in childhood do not adequately describe either the etiology or the ongoing presentation. Developmental Trauma Disorder (DTD), the label proposed for this presentation (D'Andrea et al., 2012; Stolbach et al., 2013; van der Kolk, 2005), arises from exposure to multiple or prolonged experiencing (including witnessing) of interpersonal violence together with disruptions of protective caregiving (either lack of attending and/or protection by the primary caregiver or repeated changes in caregiver—i.e., relational trauma). The diagnosis of DTD was not recognized in DSM-V (American Psychiatric Association, 2013) because of the limited research available, as well as concern that the diagnosis is based substantially on the etiology rather than being based on descriptive characteristics (as with other DSM diagnoses) (Schmid et al., 2013). There were also concerns that biological causes and/or comorbidities might be overlooked with a DTD diagnosis. Despite lack of formal psychiatric designation, DTD has becoming a working diagnosis for many therapists working with distressed children who have experienced early relational trauma. Use of the DTD diagnosis avoids the multi-diagnostic formulations that are so often given to these children (Stolbach et al., 2013), encourages trauma-focused (as opposed to solely pharmacological or behavioral) therapy, and directs attention to a child's environment as well as to the child (Kisel et al., 2014). This diagnosis is particularly important for children experiencing dissociation that disrupts their day-to-day functioning (see, in particular, the criteria of affective and physiological dysregulation, but also attentional and behavioral dysregulation, and self and relational dysregulation) but is not at a level that a DID or even DDNEC would be diagnosed. As specific treatment models are developed to address DTD, dissociation-focused interventions appropriate for mild to moderate levels of dissociation will need to be included as an integral part of the treatment plan (see Wieland and Silberg, 2013).

Although dissociation can be expected to occur within children who are traumatized, the majority of children who experience trauma do not develop an extreme dissociative disorder, in particular DID. Recognizing this early on, Kluft (1984) proposed a four-factor theory to explain the development of dissociative identities. The initial factor is described as a biological capacity to dissociate; the second is the occurrence of traumatic experiences that activate the defense mechanism of dissociation; the third is the linking of the dissociative defense with a part of the self-system; and the fourth is the absence of a nurturing or supportive environment during early development.

Later research indicates that the first factor would be more accurately described as a familial factor. Although individuals with DID are highly hypnotizable (Frischholz et al., 1992), other studies have indicated a lack of correlation between hypnotizability (understood as a biological factor) and dissociation (Putnam et al., 1995). There is clearly, however, a tendency for dissociative disorders to cluster in families (Yeager and Lewis, 1996). For many of these families, violence (trauma) may be continuing to happen. For other families, where the trauma was outside the family or the trauma has stopped, the parent may continue to demonstrate dissociative-type behaviors, or may be dissociative. The child, through modeling, learns to avoid feelings, thoughts, and memories from the past —that is, learns to dissociate (Mann and Sanders, 1994; Putnam, 1997; Yeager and Lewis, 1996). Dissociation, as distinct from dissociative identities, has been found in adolescents to correlate not only with an occurrence of sexual abuse, but also with negative home atmosphere (Sanders and Giolas, 1991).

The second factor, a traumatizing experience, was discussed earlier (pp. 1 and 6). Kluft's third factor, the linking of the dissociative experience to a part of the self-system, draws attention to research and highlights the relationship between early onset of trauma (as a child's sense of self is developing) and dissociative identities (Cole and Putnam, 1992; Dorahy and van der Hart, 2007; Putnam, 1997). Dissociation without the separation into identities is more likely with later-occurring abuse.

Kluft's fourth factor postulates that the lack of "nurturing and healing experiences" (1984: 130) during the early years determines whether dissociation develops to the point of separating individual functions. Severe trauma can happen without any ongoing dissociation if the parent-figure is able to re-establish a sense of safety for the child, and is able to listen to and process with the child the feelings and sensations experienced at the time of the trauma. This would mean the parent would stay attuned to whatever distress (emotional, physical, or indeed cognitive) arose in the infant or child, and allow that distress (crying, shaking, or words) to be experienced within a safe setting, and then provide soothing (Levine and Kline, 2007).

Dissociative Symptoms

These categories—mild dissociation, moderate dissociation, and extreme dissociation—can help a therapist organize his or her thinking and treatment plan but do not necessarily help with identifying dissociation when initially meeting with the child or the parent. What should the therapist be looking for? Abrupt shifts in the child's demeanor or attitudes can alert the therapist to the possibility of dissociation. Extreme changes often appear in the way the child behaves, expresses emotions, or learns, and even in the physical conditions the child experiences. With some children the changes can be very subtle, considerably more subtle than those seen with adults (ISSTD, Child and Adolescent Committee, 2008). These changes alone, however, do not necessarily mean dissociation. Similar changes may occur with other mental health problems. Nonetheless, they can alert the therapist to the possibility of dissociation.

Behavioral changes are often the easiest to notice. A dissociative switch within a child may cause the child to suddenly act much younger or much older than the child's chronological age, or to suddenly become aggressive when normally passive or accommodating. A child with dissociation may be able to do certain skills at one time and not at another, or may strongly prefer a certain game, clothing, or food at one time and completely dislike that at another time. The child's voice may switch dramatically. In some cases, a child may refer to herself by different names or as "we." The child may present from time to time with a blank stare or "empty" eyes. Therapists who have worked with adults need to be aware that these shifts are often more subtle in children.

Emotional shifts in children with dissociation can move rapidly from one emotion to another without the intermediate stages that are apparent in most children. The dissociative child's emotions may not fit the situation. The child may laugh when she sees someone hurt or when something sad is discussed, or may become angry when a positive situation is happening. In other situations, the child may present as blank, as if having no feelings of any type.

Cognitive shifts can also be observed. Children who dissociate may be able to do an assignment well on one day, be unable to do the same work the next day, and yet on the third day, and with no additional teaching, be able to do the task again. The child may have no memory for past experiences and no memory for things she has done just previously. At one point, the child may feel quite hopeful and the next moment feel very discouraged or even suicidal. The child may be aware of voices inside her head. In some cases, the child is able to hear what these voices say and, in other situations, is simply aware of the voices or noise but is not able to actually tell what is happening. Internal voices tend to be menacing toward the child or others. In some cases, the child may have experiences of "outside figures" threatening him or her.

Physical difficulties for which there are no medical explanations may also indicate dissociation and may constitute somatoform dissociation (Nijenhuis, 2009). This is particularly true for physical symptoms that come and go, such as difficulty with walking, fainting spells, or pain in a particular area of the body. A child who is able to dissociate body pain may be hurt and not know that she has been injured. The child may find that she has wet or soiled herself without knowing (feeling or smelling) it has happened.

For some children, dissociative changes occur every day or several times a day, and the switching can be as rapid as 30 to 60 seconds. For other children with dissociation, the changes may only occur from time to time. Although research is needed regarding how often children switch, clinical experience indicates that the frequency of dissociative changes relates to the level of the dissociation (more often with more extreme dissociation), to the degree of felt safety in the environment (less often with a greater sense of safety), to the emergence of trauma memories (more often as memories arise), or to the availability of therapy (more often at the beginning of therapy). With the beginning of therapy, the child is likely to become more aware of both internal distress and memories, as well as more aware of the ongoing dissociation.

Many of the symptoms mentioned also occur with other childhood disorders; for example, Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, Bipolar Disorder, and PTSD. This similarity in symptoms means that dissociation is often mislabeled as another disorder. In addition, dissociation can be comorbid with those disorders. As a result, therapists and doctors may overlook the diagnosis of dissociation. Lack of training in graduate institutions related to the area of dissociation explains some of this oversight. In addition, the DSM-V (American Psychiatric Association, 2013) does not list dissociative disorders under "disorders usually first diagnosed in infancy, childhood, or adolescence," and the adult criteria miss many of the childhood features. The reluctance of professionals to ask about early trauma, together with the reluctance of parents to talk about early negative situations, particularly dysfunction within the immediate family, means that the possibility of trauma effects and dissociation being the underlying cause of ongoing symptoms is all too often overlooked.

The children themselves are unlikely to report dissociative symptoms for several reasons. A child who has, for most of her life, heard voices inside her head and lost track of time or experienced discontinuity of events may have no realization that this is not everyone's reality. Sharing feelings and internal experiences is discouraged and often punished in dysfunctional families. When children become aware that their experience is different, they are often frightened to report it for fear of ridicule or punishment. In addition, children may not have the words to describe their experience (Yehuda, 2005) and little motivation to do so. Dissociation has kept the

painful feelings, sensations, and memories away—why would they want them back (Wieland, 1998).

Measures to assess dissociation in children and adolescents have been developed slowly over the years. The Child Dissociative Checklist (Peterson and Putnam, 1994), to be completed by parents or other adult observers, has shown good reliability and validity (reported in Silberg and Dallam, 2009). The Children's Dissociative Experience Scale and Traumatic Stress Inventory (Stolbach, 1997), the Adolescent Dissociative Experience Scale (Armstrong et al., 1997), and the adolescent version of the Multidimensional Inventory for Dissociation (Ruths et al., 2002), completed by the child or adolescent, are helpful in diagnosing levels of trauma and dissociation. A child's drawings and play may include multiple parts and/or shifting realities (Malchiodi, 1997; see also Chapter 5, this volume). Observation of a child's or adolescent's behavior, together with response to interview questions and parental observations (Silberg, 1996, 2013; Silberg and Dallam, 2009; Waters, 2005; Wieland, 1998) continues, however, to be the most important method of diagnosing dissociation in children and adolescents.

Why Dissociation Occurs

Having a framework for dissociation and how it may appear in children is only a beginning point for a therapist. There needs to be some understanding for why dissociation occurs. Research has shown that dissociation is a reaction to immediate trauma in the child's world (Ogawa et al., 1997; Putnam and Trickett, 1997). Children react to trauma first with hyperarousal. As the child moves higher along the arousal continuum, the hypoarousal (dissociative) response is activated (Perry, 2006; Scaer, 2005; Schore, 2009, 2013). There is a decrease in heart rate together with decreased perception of anxiety and pain.

When talking about trauma, it is important to recognize what may be a traumatic situation for one individual may not be traumatic for another. When overwhelming feelings of helplessness arise, "trauma" exists. Ongoing dissociation, the topic of this book, occurs not when trauma happens but when the support and soothing that could help a child through a trauma do not become available. It is then that a child must self-protect.

Dissociation in children has been documented following sexual and physical abuse. Abuse to the developing sense of self within the child (i.e., emotional abuse) can also lead to dissociation. Verbal abuse from parents or peers (in particular, during the middle school years) has been found to lead to high symptoms of distress, including dissociation. In particular, chronic neglect of physical or emotional needs requires an infant or child to dissociate these needs from awareness. Witnessing violence within the family or in the community can place a child, first, in a state of hyperalertness and then in a state of psycho-biological withdrawal that can then

evolve into dissociation. Being removed from or experiencing the loss of the important parent figure (by actual loss or in some other manner, such as severe parental depression or parental drug use) also disrupts the child's safety and can lead to dissociation. Any emotionally overwhelming experience where a safe adult is not able to protect, or to provide safety and emotional support following the experience, can lead to dissociation in a child.

Dissociation has also been found to occur when there is no direct negative impact (action or lack of action) from the parent to the child. When a parent-figure is experiencing psychiatric distress—severe depression, psychotic episodes, flashbacks, dissociative absences, dissociative shifts in demeanor—or negative effects from drug or alcohol usage, the infant or child may become frightened and emotionally disorganized. This, as with direct abuse, creates a disorganized attachment pattern between the child and parent in which not only can the child not rely on the adult for support, but also may perceive themselves as the cause of the parent's distress (Liotti, 1999, 2009). This disorganized attachment pattern (discussed further in this chapter, in the section "Disorganized Attachment Model") makes a child highly vulnerable to dissociation (Harari et al., 2007; Liotti, 1999, 2009; Schore, 2013). Dissociation may become the means by which a child is able to survive living with and loving a parent who is abusive or absent.

Antecedents to dissociation can occur outside the family. Being in or witnessing a natural disaster (e.g., earthquake, flood), being in a frightening or extremely painful accident, or undergoing painful medical conditions or procedures may activate a dissociative response. Severe and chronic bullying may also lead to a need for internal escape (i.e., dissociation).

None of these events by themselves will cause chronic ongoing dissociation. If the child is in a supportive environment and the parent-figure can provide safety and reassurance after a trauma event, the child does not need to continue to escape his world. When, however, there is no safety or security to rely on, the child's use of dissociative coping skills is highly likely to continue and, in time, become implanted within the child's neuropsychological processes.

Theories of Dissociation

Joyanna Silberg and Stephanie Dallam (2009) provided an excellent review of the literature on dissociation in children and adolescents. This literature, although increasing in recent years, is still quite small compared with the writings on research and treatment with adults. For this reason, the present section will consider work related to adults as well as children.

This section will look briefly at research and theory regarding dissociation and neurobiology, and will then turn to conceptual models

related to the development of dissociation. The present discussion will consider Putnam's (1997) discrete behavioral states model, Liotti's (1999, 2009) disorganized attachment model, Silberg's (2013) affect avoidance model, Watkins' ego-state model (Watkins and Watkins, 1979, 1993), and the structural dissociation model of van der Hart et al. (2006). These models have been placed in a sequence according to the population being looked at by the model—infant, infant/toddler, child/adolescent, adult. Each model will be briefly described and, then, how the model can be of assistance to therapists working with children and adolescents will be discussed.

Neurobiology and Dissociation

Since the mid-1990s, research on mental health issues has been increasingly directed toward understanding the neurobiology of these disturbances. This is a relatively new area of research for dissociation and is now starting to offer some direction for our clinical work as therapists.

Research with adults and with animals has looked at the functioning of the hypothalamic–pituitary–adrenal (HPA) stress axis with particular attention to the secretion of cortisol, the hormone related to stress (de Kloet and Rinne, 2007). With some situations of early trauma, the HPA axis becomes abnormally activated; this leads to a situation of hyperresponsivity (oversecretion of cortisol), which over time may lead to a lower threshold of the axis (i.e., more sensitive to stress). Some chronically traumatized individuals have been found to have low baseline levels of cortisol and may, as a result, have less resistance to debilitating intrusive thoughts and over-reactivity when under stress. Others respond with high cortisol levels that may lead to an increased blocking of what has happened or is happening. This blocking may be a factor in the development of dissociation. It also may also be a factor for children and adults who were previously abused and then become less aware of (seeming immune to) abusive behaviors directed toward them. Hippocampal and pre-frontal areas, both of which have a high number of glucocorticoid receptors, which appear to be particularly sensitive to cortisol, have been found to be negatively affected by high levels of stress (high cortisol secretion). Difficulty with memory and executive functioning frequently occurs in children and adults who have experienced severe abuse and/or neglect (Carrion et al., 2013).

Neuroimaging research with children is of particular interest to child therapists. Reduced hippocampal (memory) volume has been found to occur when abuse occurs during particular age periods (3–5; 11–14) (Teicher, 2010). A study of 10–17-year-olds with posttraumatic stress symptoms following interpersonal trauma showed reduced hippocampal activity (both right and left) during memory retrieval as compared with non-traumatized controls (Carrion et al., 2010). The reduced activity in the left hippocampus correlated with the severity of avoidance and

emotional numbing (dissociative-type characteristics) experienced. In addition, alterations in the corpus callosum (fibers connecting the right and left hemisphere) have been found in young adults who experienced maltreatment during childhood (Teicher, 2010) and may influence the ability to integrate information (see Brewin's dual representation theory of PTSD, pp. 17–18).

Increased amygdala (fear/anger center of the brain) volume has been found in children who experienced early (birth–2 years) sensory deprivation (Tottenham et al., 2010). When these children (adopted from deprived orphanage settings) were presented several years after adoption (average age of 10 years) with a fearful (but not frightening) face, amygdala activity increased (relative to non-adoptees) while activity in the ventromedial prefrontal area (the area of the brain that has neuronal connectivity that helps to regulate the amygdala) did not change. For non-adoptees, pre-frontal activity showed an inverse pattern to amygdala activity, indicating regulation of a fear/anger response. Significantly, recent studies have indicated a lower density of neuronal connections between the frontal cortex and the anterior temporal lobe, including the amygdala for children who had experienced abuse (see McCrory et al., 2010). This will mean less conscious control over negative emotional reactivity. Studies have shown reduced pre-frontal cortex volume (particularly in the right hemisphere, Hanson et al., 2010), as well as reduced pre-frontal activity in children who had experienced early abuse or had received a posttraumatic stress diagnosis (see review, Carrion et al., 2013). Decreased cerebellum volume (emotion processing) has similarly been found for children and adolescents who had experienced maltreatment (see Carrion et al., 2013; McCrory et al., 2012). While these brain anomalies have not been specifically associated with dissociation, they do indicate dysfunctional brain activity which could contribute to emotional responding or non-responding outside conscious control. Schore (2012), integrating his own work with other recent neuroimaging research, has highlighted the failure of the right orbitofrontal cortex, the right anterior cingulate, and the right insula to regulate the right amygdala, and has linked this failure with the occurrence of pathological dissociation. Schore has stated, "The symptomatology of pathological dissociation can thus be conceptualized as a structural impairment of a right brain regulatory system and resultant functional deficit of affect regulation" (2012: 293). See pp. 16–17 and 19, for further discussion of Schore's work.

Other research has looked at brain functioning in adults diagnosed with dissociation (Lanius et al., 2007). Changes in the activity of the insular prefrontal cortex, temporal cortex, parietal cortex, anterior cingulate gyrus, thalamus, and the amygdala during dissociative responses to trauma reminders have been studied. Distinctive differences were found for individuals experiencing dissociation as compared with control subjects when both groups were presented with trauma scripts. For example,

distinctive dysfunctions in right insular (the area related to awareness of pain and visceral sensations), left thalamus (the gateway for body sensations reaching the brain), and hippocampal (memory) activity have been found in individuals with dissociative responses (Bremner, 2009; Lanius et al., 2007). Neuroimaging has shown decreased activation within the medial prefrontal cortex and the anterior cingulate cortex (that part of the brain involved with both executive functioning and emotional control), together with increased activation within the limbic system, most notably the amygdala (fear/anger) and the hippocampus (memory), for individuals experiencing hyperarousal (referred to as "primary dissociation/flashbacks" by Brand et al., 2012). This is very similar to the findings for children experiencing early deprivation, as discussed earlier (p. 15).

For individuals showing a dissociative/hypoarousal response to trauma reminders (referred to as "secondary dissociation/depersonalization" by Brand et al., 2012), activation increased within the medial prefrontal cortex and the anterior cingulate cortex (Lanius et al., 2013) with concomitant over-modulation of the amygdala and the hippocampus (Brand et al., 2012; Schmahl et al., 2010). This would explain the hypoemotionality experienced with depersonalization, derealization, and dissociative amnesia. Particularly interesting, when considering the different presentations seen in individuals with DID, is the research by Reinders et al. (2006) who found significant differences in both cardiovascular response and regional cerebral blood flow for two distinct self-states within a single individual when exposed to the same trauma information. This supports the hypothesis that different neuronal patterns are associated with the processing of trauma information by different dissociated self-states.

Schore's research (2003, 2009, 2012, 2013) on the effect of early abuse and neglect on the early development of the right brain highlights the negative effect of early trauma (in particular, relationship trauma) on limbic-autonomic circuits in the cortical and subcortical areas of the right brain. As described by Schore, the right hemisphere, which holds the primary processing for self-awareness and self-identity, has the strongest connectivity with the limbic system and from there to the brain stem and autonomic nervous system functioning. The high activation state caused by early overwhelming distress increases the activation of the sympathetic nervous system with rapid over-arousal of the infant's physical system leading to the release of stress hormones. These hormones negatively impact the infant/toddler's right hemisphere (that part of the brain which is functioning during the first 18 months of life). When there is no relief of this over-aroused state, the parasympathetic (most notably the dorsal-vagal system; Porges, 1997) nervous system takes over and the brain/body system shuts down (Schore, 2013). This shift from high sympathetic response (hyperarousal) to extreme parasympathetic response (hypoarousal), with its concomitant effect on the infant-toddler brain, is

hypothesized by Schore (2013) as leading to an over-pruning of the right cortical-limbic system. This part of the brain—which is so crucial for social interactions, for sustaining attention, for processing pain, and for emotional regulation—is compromised (research referenced in Schore, 2013). Schore (2009) described the right cortical hemisphere as losing its capacity to integrate sensory processing, thus disrupting the integration of ongoing perceptual information. As noted, these deficits in right hemisphere functioning are particularly relevant to dissociation in that the right hemisphere is "specialized for generating self-awareness and self-recognition" (Schore, 2009: 127). Dissociation, in turn, impairs the brain's ability to appraise safety (a right hemisphere function) accurately, a situation that leaves the individual in a continuing vulnerable position (Schore, 2012).

As a result of the high intensity of early (infant-caregiver) attachment interaction, Schore (2012) hypothesizes that, as the infant of a mother with dysregulated states matches the mother's states, the firing patterns of the infant's stress-sensitive cortico-limbic regions of the brain (in particular, the right hemisphere) would register a dysregulated pattern. This pattern would be highly likely to include dissociated processing. This may, indeed, be the dynamic that leads many of the early theorists to think there was a genetic component to dissociation.

Perry (2006, 2009) has emphasized how the area of impact from abuse and neglect on the brain relates to the stage of brain development occurring at that time. When trauma happens during infancy, the lower areas of the brain—brain stem and diencephalon—regulating bodily functions and arousal are most affected. During the toddler years and into early childhood, the limbic system with emotional reactivity and attachment patterning is most affected. During childhood and then adolescence, the cortical areas of the brain become more active and are, therefore, more directly impacted by trauma. Because early trauma imprints are below the cortical level, the child, even as she becomes older and moves into a safer setting, may continue—outside of conscious awareness—to respond with over or under reactivity to cues of early (but not present) impending threat (triggers) (see research reported above related to children raised in deprived settings on p. 15). A child's or adolescent's functioning may then revert to the brain level that was dominant at the time of the abuse. This shift in functioning may be relevant to the dissociative switching experienced by children who have experienced abuse and/or neglect.

Brewin's (2005) dual representational theory of PTSD also addresses brain functioning. Brewin postulates that trauma is encoded within implicit memory, primarily a right hemisphere function. This memory is primarily image-based with the encoding of sights, sounds, smells, movement, and body response (e.g., heart rate, pain). This memory does not have contextual detail and thus does not fit into categories of past, present, or future. Brewin refers to this as *situationally accessible memory* (SAM) and, when this implicit memory arises, it feels like it is happening now (intrusive

thoughts, flashbacks). In contrast, explicit memory, primarily a left hemisphere function, is available to the individual in words and becomes contextualized within the person's life history. These memories, referred to as *verbally accessible memory* (VAM) can, because of the left hemisphere's capacity to process sequentially, be placed in the past with recognition of what has passed since that time. While Brewin's discussion deals with PTSD, this division of memory is relevant to dissociation. Memories existing in SAM need to be protected against because they are experienced as happening in the now. Dissociation forms such a protection.

Howell (2011), in her careful analysis of dissociation and of the dissociated self-states, refers to the possible role of mirror neurons in establishing within an individual a neuronal activation that parallels the neuronal activation occurring in an observed person (e.g., parent, abuser) and not consistent with the individual's own way of being. When an individual, for example a child, is hit, the child is also observing the hitting. With this observation, and also with the observation of someone hitting another person, mirror neurons within varied areas of the child's brain including motor and sensory areas are activated and "learning" of that activity (hitting) occurs (Gallese et al., 2007). At the same time, because of the shifts within both the brain and the autonomic nervous system (as discussed above on pp. 14–20), and possibly earlier contradictory learning ("hitting is not to be done"), this learning through observation/mirror neurons would not be able to be consolidated within the child's basic sense of self, or within the child's normally occurring behavioral repertoire. Without support and comforting, there would be no processing of or reparation related to this negative behavior. The aberrant learned behavior would then be held separately within the brain and the child could, indeed, experience it as another part of self.

Although this research (with the exception of Carrion et al., 2013; Perry, 2006; Perry and Dobson, 2013; Schore, 2012) does not give specific direction to the therapist in the room with a child, it does highlight several concerns that are pertinent for the therapist (see, in particular, Lanius et al., 2013; Schmahl, et al., 2010; Schore, 2013). While working with the child and family, there needs to be a decrease in ongoing stress. This decrease, which implies an increase both in safety and in sense of safety, is essential if there is to be a decrease in the activation of the HPA and, with time, correction in dysfunctional cortisol reactivity. Because of the close connection between the HPA and the autonomic nervous system (ANS) within the right hemisphere (Schore, 2012), a decrease in stress would enable a settling within the ANS.

The research related to trauma effects on cortical-limbic connectivity and limbic-autonomic nervous system connectivity highlights the need for new experiences of calming to counteract the early dysfunctional imprints of high activation and freeze. Perry (2006, 2009; Perry and Dobson, 2013) described a neurosequential model of therapeutics that emphasizes the

importance of targeting the part of the brain that was most sensitive to development at the time abuse or neglect was occurring. This would be that part of the brain that was unable to develop as it should have owing to the disruption from abuse/neglect. Perry states that treatment must address the innervating neural system not symptom behaviors. Cognitive work should not be attempted until earlier disrupted levels have been remediated.

For children abused early in life, initial therapy should focus on calming the brain stem and diencephalon. Perry recommended patterned, repetitive somatosensory activities such as music, movement, breathing, drumming, and therapeutic massage for this subcortical calming (Perry and Hambrick, 2008). Only after that work is done, according to Perry and Dobson (2013), can relational and cognitive therapeutic work be successful. And, even at that point, the therapeutic experiences need to be developmentally appropriate for the child's distress level (the age the child was at the time of the trauma), rather than the child's present age (Perry, 2006).

Schore (2003, 2012, 2013) has emphasized the importance of having these experiences occur within a potentially secure attachment relationship. For children, this means therapists paying attention to the relationship between the child and the parent-figure. Not only should the therapist be attentive to the child's body and facial expressions (more indicative of the right hemisphere-held early relational trauma than is verbal expression), but also to the body and facial expressions of the parent-figure (Schore, 2012). If the parent-figure is showing distressed or dissociative reactivity, then therapeutic attention needs to be directed to the parent as well as the child (Schore, 2012; Wieland and Baita, in press). With all parent–child dyads, attention needs to be given to the development of right hemisphere to right hemisphere communication (e.g., eye-gaze activities, empathic mirroring). The parent is encouraged to follow the child's lead when playing, and to be available to engage in supportive activities with the child. In this manner, the neuronal connections in the right hemisphere related to healthy attachment functioning can be strengthened. In particular, Schore (2013) and Chapman (2014) emphasize right hemisphere related activities for the child (art, play, imagery), with the therapeutic focus being more on development of affect tolerance and safety within a secure attachment experience rather than on a retelling of the trauma. This, according to Schore (2013), will enable a lowering of dissociative defenses, thus allowing the child to move toward internal processing of the trauma. While Schore emphasizes the importance of right hemisphere processing within therapy for all traumatized individuals, he highlights the particular importance for individuals with dissociation in that the right hemisphere is dominant for the processing of self-related information (Schore, 2012).

In their differentiation between hyperarousal PTSD and dissociative PTSD, and in their work related to dissociative disorders, Lanius et al.

(2013) and Schmahl et al. (2010) have emphasized the importance of increasing relational and emotional engagement, as well as decreasing dissociative barriers, before engaging in trauma-related therapeutic work. Relevant here would be the development of positive inter-relationships (including the therapeutic relationship) and the ability to self-soothe or ground oneself (Schmahl et al., 2010).

Awareness of functional changes within different areas of the brain highlights for the therapist the need to be attentive to helping the child become aware of the many different emotional and body responses, the perception of which may have been cut off through dissociation. The child's brain may need to be retaught (or, for very early dissociation, taught) how to be aware of physical, emotional, and cognitive responses. The child may need to be taught to see and recognize his or her body and body reactions as part of herself. The dysfunctional medial-prefrontal cortex (over-activation)—amygdala (under-activation) connectivity and the possible pruning of connectivity networks that occurs for traumatized individuals highlights the importance of calming the medial-prefrontal area with activities such as mindfulness and/or meditation (Siegel, 2010).

Knowledge of memory systems and possible corpus callosum pruning alerts the therapist to the importance of moving from image or sensation memory (SAM) to verbal memory (VAM) (Brewin, 2005). With children, it is often easier to recognize trauma memory from a child's behavior or pictures than from the child's words. Indeed, with early occurring trauma, memories are usually nonverbal. Once memories are accessed, words can be put to them (primarily the job of the therapist: Wieland, 1997), thereby helping to move them into VAM where they can be contextualized as something in the past and not in the now. The trauma memories can be known at the same time as the child experiences present safety and positive future possibilities. This provides the basis for trauma processing (Briere and Scott, 2006), an important part of therapy for dissociation.

Understanding the action of mirror neurons, therapists can help children understand where some of their behaviors or thoughts that feel so alien come from. Once parents and children realize that the child's learning and subsequent display of behaviors from past abusive or neglectful settings was not of their choice, both parents and child are less likely to engage in blaming. This understanding can encourage new learning from mirror neuron activity within the present safer home setting and within the therapeutic sessions.

Perry (2006) emphasized the importance of repetition within therapy. Brain areas neuronally organized early in life are not going to change in later childhood unless sufficient repetitions are provided. This is a concept particularly important for parents to understand and appreciate. Early nurturing experiences are going to need to be repeated over and over again for these children. Engaging parents and group home workers within the therapeutic process is very important (Perry and Dobson, 2013).

Discrete Behavioral State Model

With research related to the brain and dissociation still in its infancy, conceptual models are an important aid to therapists. Putnam's discrete behavioral state model (1997) looks at how connections between behavioral states as well as the development of moderate or connecting states that normally occur as the infant or child develops can be interrupted by trauma, thereby leading to dissociation.

Putnam (1997) based his model on the work of Wolff (1987), who described the discrete behavioral states—drowsy, irregular sleep, regular sleep, fussy, cry, feeding, alert-inactive—that are present within the infant at 1 month of age and the limited neuronal pathways between these states. By age 3 months, these states have increased to include the state of "alert-active," and many more connections have formed between behavioral states. The connections are developed in response to innate biological growth, together with the mirroring and reflecting the infant receives from the surrounding world. As the infant or child develops, behavioral states continue to increase and become self-organizing and self-stabilizing. With healthy development, the connections, or what Putnam refers to as "state-bridging metacognitive capacities" (1997: 163) develop and the child starts to experience an integrated sense of self. If, however, trauma occurs, this development is interrupted in two ways: the positive state-bridging capacities are interrupted; and fear-conditioned or trauma behavioral states develop. Basing his observations on the neurobiological work of Perry et al. (1995), Putnam described the trauma-related behavioral states with associated pathways as developing from the cellular and synaptic firing that occurs within the infant's or child's brain during trauma. Without positive caretaking experiences, the metacognitive linkages (neuronal pathways) between healthy states do not develop. The child does not achieve an integrated sense of self and is left with trauma-related and disconnected states.

Putnam's model highlights the emergence of dissociation when the basic elements of a healthy integrated self do not develop: (1) trauma-related states replace the moderated self-states that would have developed if there had been enough positive interaction with the world (parent-figures calm over-aroused states and stimulate under-aroused states), and (2) state-bridging capacities built by positive interaction with the world (parent-figures acknowledge the child's negative state and then, together with the child, move to a positive state) do *not* occur.

This lack of moderate states and lack of bridging capacity within a child who dissociates provides two directions for the child therapist. First, the therapist needs to provide calming when over-activation occurs and activation when under-arousal occurs—in essence, building moderated states. The second direction to therapists from Putnam's model is the importance of bridging between states. Following this directive, therapists

need not only to acknowledge the child's emotional and physical trauma states, but also to create links between those states and other states within the child. These other states may hold the physical sensations or emotional responses that were split off from the trauma experience, or they may hold information on the child's present world that is now safe (or at least safer than at the time of trauma). As the therapist creates bridging through play, art, or words, the child can start to develop bridging networks.

As the therapist attunes to the child's state and provides modulation, the therapist is doing the "holding" and attending necessary for healthy infant and child development (Winnicott, 1969). Modulation may come from the therapist self-modulating, from the therapist giving verbal acknowledgement of the child's state, and from the therapist moving with the child to another calmer form of activity. As the therapist shifts from a state attuned to the child's distress to a new and calmer way of being or doing something with the child, he or she models a linking of internal states. The therapist may reflect on his or her own shift, may note the shift in activity, may inquire what the child needs at that point, may seek to provide greater safety or stability, or may reflect on the difference between past and present events. These shifts are modeling linkages and, when the child becomes engaged, helping to build linkages.

Disorganized Attachment Model

Liotti's (1999, 2009) model for understanding dissociation looks at the bonding schemata—attachment—created between the mother-figure and child. Extensive research on attachment established four basic categories: secure, avoidant, ambivalent, and disorganized (Main and Solomon, 1990). Even though avoidant, ambivalent, and disorganized are all considered insecure forms of attachment, disorganized attachment stands out from the others in that the mother-figure shifts dramatically in her interactions with the infant or child. The mother within this classification does, at times, provide caretaking and comfort. At those moments, the child experiences the mother as the comforter and experiences the self as the comforted child. At other moments, however, this mother becomes very needy and uses the child to comfort herself—and so the child experiences the mother as needing comfort and the self as the comforter. The disorganized attachment mother may directly hurt or frighten the child. The child then experiences the mother as frightening/hurtful (persecutor) and the self as frightened/helpless (victim). At yet other times, the mother becomes frightened. This frightened reaction may be a result of what is happening at that moment (domestic violence, self-injury), or may be a result of earlier experiences the mother had (flashbacks, internal distress). When the child experiences the mother as frightened or hurt (victim), the child is put in the opposite position (persecutor)—as if the child is the one who frightens or hurts. As a result, the child's internal working model (Bowlby, 1971) holds multiple

senses of mother ("mother" being the child's earliest representation of the world): comforter, needing comfort, frightening or hurtful, frightened or hurt. In response, the child forms multiple senses of self: I am comforted; I must comfort; I am hurt/helpless; I hurt/frighten others.

Liotti (1999) described the last three positions as the drama triangle. The child assumes three separate positions with regard to her world: rescuer, victim, and persecutor. These positions cannot be reconciled; thus, the child is left with multiple, disconnected senses of self. This fragmentation of the child's internal working model of self is not dissociation. Separation between the feelings, sensations, memories, or selves may not have occurred. This fragmentation, however, makes the child vulnerable when overwhelmed beyond what the child can cope with (i.e., experiencing trauma). When that happens, one or more aspects of the self—rescuer, victim, persecutor—becomes overwhelmed. That part of self may distance or dissociate from the rest of the self in order to preserve (keep from being overwhelmed) the rest of the self—the process of dissociation would begin.

Although not discussed in detail by Liotti, dissociation can also occur for children who experience other attachment patterns (secure, avoidant, ambivalent). Although these children (as opposed to children with a disorganized attachment pattern) would develop through the infant and toddler years an integrated sense of self (Harter, 1983), if trauma occurs for which the parent-figure is unable to provide (or does not recognize as being needed) adequate soothing and processing, the experience may be "pushed away"/"cut off" to such an extent that some level of dissociation occurs (see Chapter 6). Emotions, sensations, or memories may be dissociated. It may be that an attachment pattern other than disorganized attachment may protect a child from extreme dissociation (DID) but not from DDNEC, or more moderate experiences of dissociation. This is a hypothesis that needs to be studied.

Liotti's focus on attachment provides the child therapist with a very important direction when working with dissociative children. Whether the child is in a foster family, in an adoptive family, or in the birth family, the attachment pattern needs to be assessed and difficulties within the attachment need to be addressed (Music, 2014). The child with dissociation will continue the earlier learned attachment pattern within her present family. In a new family (foster or adoptive), the child's disorganized attachment pattern (1) may meet a healthier attachment model within the parents, or (2) may draw out an early disorganized attachment experience of the parents. In the first situation of a family with a healthy attachment pattern, the child will initially experience high levels of distrust that may or may not disrupt the parents' functioning. If the parents are able to provide secure attachment experiences despite the child's distrust and fragmented presentation, and if the parents are able to provide attunement, modulation, and linking to a more positive present-day experience despite the child's shifting presentation, then the child may be able to learn a new attachment

pattern. Most parents need considerable assistance with this, as well as increased understanding of dissociation—why it happens, how it presents, and how they as parents can strengthen integration within the child. Unfortunately, all too often the child's dissociation blocks the child's learning about this new healthy experience (see Chapter 3).

In the second situation, early disorganized attachment experiences of the parents are triggered. These parents are going to need therapy (to address their attachment issues) and, unfortunately, in some cases, a move to a different family may need to be considered. When the child stays within the birth family where disorganized attachment first occurred, therapy for the parent will be essential for the child's world to truly stabilize. Therapists need to remember that a parent with a disorganized attachment pattern can look very healthy from the outside. These parents can present as quite competent when their attachment system is not being threatened. Children always pull on attachment systems and children who were traumatized will frequently trigger a parent's old insecure attachment pattern. These children may retrigger the parent's own trauma. These parents need to process their trauma and to begin to experience a new form of attachment. This ideally would occur within their personal therapy. Parents need to become aware of and process their triggers, and experience a healthy therapeutic attachment if they are to be able to shift their responding to the child and, thus, the attachment pattern between themselves and their child (Wieland, 2007). When the parent is unwilling or unable (financially) to do this, it will be important for the child's therapist to attend carefully to the parent's attachment needs even while working with the child (Wieland and Baita, in press).

Liotti's model alerts child therapists to the need for focus on the attachment relationship between the parent and child. Therapists need to also be aware that different parts of a child may have different attachment patterns with the parent-figure, each of which will need to be addressed. The younger part of the child (the part that experienced the neglect and/or abuse) may not know about a new (foster or adoptive) parent (see Chapter 4). Attention to attachment issues is critical throughout a child's therapy.

Affect Avoidance Model

The affect avoidance model of dissociation (Silberg, 2013) incorporates Affect Theory as developed by Silvan Tomkins. Tomkins proposed nine discrete affect states that people experience biologically—six being negative (anger-rage, fear-terror, distress-anguish, disgust, dissmell, shame-humiliation), one neutral (surprise-startle), and two positive (interest-excitement, enjoyment-joy). Because the affects stimulated by frightening situations (this may be the occurrence of a hurtful event, or the lack of a nurturing event) are aversive, the infant/child who does not receive outside comforting and reassurance is left very vulnerable. To relieve this

vulnerability, the infant/child blocks those experiences. This blocking may include avoidant behaviors such as fighting, hiding, or acting out. These behaviors, as highlighted by Silberg, tend to evoke negative reactions in parents, a situation which creates further aversive affect for the infant/child. This reinforces the child's need to avoid anger/fear/distress/disgust/dissmell/shame, thereby reenforcing an avoidant pattern of responding.

Silberg (2013: 21) describes the traumatized child's mind as becoming organized "around the principle of dissociation from affect." This "separation from" or "dissociating" can generalize to not remembering the experiences and/or not feeling the pain occurring with the aversive affect. Over time, these patterns of avoidance (changes in behavior, in memory, in body sensation) extend to other situations that may not be traumatizing but are similar in some way to the situation that originally activated the negative affect (i.e., triggers). Dissociation, based on the affect avoidance model, is defined as "the automatic activation of patterns of actions, thought, perception, identity, or relating (or 'affect scripts'), which are overlearned and serve as conditioned avoidance responses to affective arousal associated with traumatic cues" (Silberg, 2013: 150). These patterns of avoidance are understood as a reflection of multiple barriers, both structural (e.g., changes in corpus callosum, amygdala, cerebellum with maltreatment) and chemical (e.g., changes in cortisol and other neurochemical levels) to the integrative flow between networks within the brain. Neuronal shifts that block information related to negative affect similarly could block reparative information (e.g., the child is now in a safe setting).

Silberg, in her work, focuses on how an understanding of affect avoidance can inform us in our work with children and adolescents. If dissociation is the interruption of healthy flow of information within the brain, then treatment needs to focus on increasing healthy flow—a process that is built by positive interpersonal interaction (Siegel, 2010). Silberg emphasizes the importance not only of an "attuned therapist" but also "an engaged family." Within the therapy setting, the therapist works together with the child and the caregiver to understand the moments within the child's present safe world when the child shifts from behaviors that are responding to what is happening in the present situation (affect being experienced may be negative but it is not at an extreme level—i.e., traumatizing) to behaviors disconnected from the present situation (negative affect is at such a level that it must be avoided, thereby necessitating either extreme acting out or extreme freezing). Silberg refers to these moments as "transition moments." If, with the therapist's assistance, the child can recognize what it is he is trying to avoid (the affect connected to an old memory or physical pain), then with the support of the family and therapist the child can work to create new ways to handle these situations—ways in which the child can remain aware of how her world has changed and is now safe. Bit by bit, with these present positive interpersonal experiences new, healthier firing within the brain—inter-connective firing as opposed

to avoidant or blocked firing—is created. With these shifts, dissociation decreases.

Silberg (2013) presents the acronym "EDUCATE" to assist therapists in their work with dissociative children and adolescents:

> *E*ducate about dissociation and traumatic processes,
> *D*issociation motivation (why a child is dissociating) needs to be analyzed,
> *U*nderstand what is hidden/avoided,
> *C*laim the aspects of self that have been hidden,
> *A*rousal modulation/Affect regulation/Attachment,
> *T*riggers and trauma are to be processed, and
> *E*nding with learning new ways to cope.

(See Chapters 3 and 6, in particular, for examples of how these interventions are used.) E, D, U, A would be part of the first stage (safety and stabilization) in three-stage trauma therapy described in other models (Briere, 1992; Herman, 1992; van der Hart et al., 2006), T would represent the second stage (trauma processing), and E would represent the third stage (integration and moving on). C, direct interventions addressing dissociation, would be included in all three stages of the three-stage therapy model.

Silberg describes her model as building on the work of Putnam (behavioral state model); Liotti (disorganized attachment); and Schore, Siegel, and others (neurological findings). The behavioral state model highlights the rigidity and impermeability of behavioral states that occur when a child is faced with maltreatment. Silberg's automated patterns of affect avoidance are examples of such behavioral states. An understanding of attachment dynamics, as highlighted by Liotti (2009), Bowlby (1971), and Main and Solomon (1990), and the importance of creating secure attachment for the resolution of dissociation underlies much of the therapeutic work described by Silberg. Throughout her therapeutic work, Silberg emphasizes arousal modulation and affect regulation as is discussed by Schore (2013), Siegel (2010), and other neuroscientists (see discussion earlier in this chapter on pp. 18–19).

Ego-State Model

Watkins and Watkins (1979, 1993) described an ego-state model as a way of understanding dissociation. Ego-states represent patterns of behavior and feelings belonging to a situation. A child will have an ego-state for the classroom, another for the playground, and another for functioning within the family. A child will have an ego-state that holds her pattern of being when the world is going well and another that holds the child's way of being when sad or frightened. Ego-states may also represent significant

others in the child's world, primarily parents, whose ways of being (kind, cruel, attentive, indifferent) have been internalized. A third source of ego-states occurs with trauma or with rejection. The part of the self that is overwhelmed by the experience becomes a separate ego-state.

Within the emotionally healthy child, the lines or barriers between ego-states are permeable, and the child has access to the different ways of being or of feeling within the self. The child is able to move easily between ego-states and is able to use one feeling state to moderate other feeling states. Watkins and Watkins portrayed this model as a pie (the whole self) divided into many pieces (ego-states). For the healthy individual, the lines between the pieces are portrayed as dashed lines permitting movement back and forth between the ego-states. The healthy child is able to move into the ego-state that is most adaptive for the present situation.

With trauma and the development of a hurt or rejected ego-state, the child is dependent on the world around to help incorporate the part holding the hurt, fright, and so on into the self as a whole. If the family supports the child, if they let the child talk about the situation and adequately express feelings and grieve the situation while providing comfort and assuring safety, the child is able to incorporate the trauma state back into healthier ego-states. The division between ego-states remains permeable. If the trauma is denied or a secret, if the parents do not accept the child's feelings, or if there is no support or safety for the child, then the child must block off this ego-state in order to go on functioning. The lines between this ego-state and others become increasingly solid. The solid divisions are needed to keep the ego-states holding the distress from invading into other ego-states. These separation lines are such that each ego-state still has knowledge of the other ego-states or aspects of the self, but the movement between ego-states is restricted. The child may become stuck in one ego-state (e.g., rage) when another (e.g., problem-solving) would be more appropriate for what is happening at that moment.

When trauma is such that blocking/dissociation needs to become more extreme, the lines between the ego-states thicken further. This thickening represents loss of knowledge (amnesia) of the other parts and separate functioning for each part or ego-state. In order for the individual to continue to present as a functioning person, the trauma experience with its emotions and behaviors becomes totally segmented from the rest of the self. The child continues to function but not as a total integrated self. The child may experience emptiness or a sense of not being whole. The child is unable to shift to the ego-state most adaptable to the present situation, and, as a result, behavior that does not fit the situation erupts. With trauma-related ego-states and the associated feelings dissociated, the rest of the child does not have the usual warning systems to let her know that certain situations are dangerous. As a result, the child may end up in dangerous situations. In other situations, the trauma feelings (e.g., anger, fear) may

take over and destroy what could have been a positive situation. Because of the loss of communication with other ego-states, these situations/feelings are experienced without the modulation new and safer situations could offer.

In contrast to Putnam and Liotti, who were studying possible early precursors to dissociation, Watkins and Watkins were studying adults and how the internal or ego-state system would differ for individuals with varying levels of dissociation. The therapist working from this model would focus on decreasing the thickness of the barriers between the ego-state selves. As an individual—child or adult—becomes more aware of other aspects of the self, barriers thin, internal communication increases, and eventually free movement between ego-states could occur.

For the child therapist, this model emphasizes the importance of communication between the varying aspects of the self. Whether this is done by use of a pie diagram, drawing pictures of the varying parts of self, or imaging different aspects of the self, emphasis is on communication between the parts. The child is encouraged to have the parts that experienced the new safer or more valuing experiences tell the younger parts that are still caught in the old unsafe or devaluing world about the "now" world. The child is encouraged to become aware of the segmented distressing internal emotions and allow space for these negative feelings to be heard and to be felt. This model also highlights the importance of recognizing all trauma, including preverbal trauma, in order that any ego-states connected to trauma not remain behind impermeable walls.

The pie model also provides a way of explaining the dynamics of dissociation to school-age children, adolescents, and their parents (see Chapter 5). This visual representation of the varying aspects of self and the increased separation that occurs can be extremely helpful.

Structural Dissociation

The model of structural dissociation constructed by van der Hart et al. (2006), derived from Pierre Janet's initial description of dissociation (Janet, 1907), is based on the concept of the personality as a structure of action systems. Each system is understood as having innate propensities to act in a goal-directed manner. An action system includes the mental, emotional, and behavioral elements involved in that particular action. The two basic categories of action systems include: (1) action systems that enable the individual to adapt to life, and (2) action systems that defend the individual from threat.

When extreme threat occurs, the defensive action system and the adaptation action system can no longer work together. The action system involved with the particular threat is split off from the adaptive life system. This split-off action system is then referred to as the emotional part (EP)

of the personality. The remaining adaptive life system is referred to as the apparently normal part (ANP) of the personality (it continues to look normal from the outside). The phobia for, or splitting off of, the EP (the part seeking to handle a trauma that cannot be handled) at the time of the trauma enables the ANP (the remaining part) either to deny the level of trauma, or to describe the traumatic experience as not belonging to the self. The EP that split off at the time of the trauma lacks the continuing and changing life information that is available to the ANP. The present may become safe, but because of the split, the EP is still caught back at the time of the trauma.

With support and processing for the individual, the EP and ANP can reunite into a normal personality with its combined multitudinous systems. A child with immature integrative brain functions (see Putnam, 1997) would be dependent on the parent-figure to provide the support and processing necessary for this reintegration to happen. When this support and processing, referred to by van der Hart et al. (2006: 7) as "psycho-physiological regulation by caregivers," is not available, the ANP and EP continue to exist separately and ongoing dissociation occurs.

Within the structural dissociation model, further trauma may cause separation within the EP, whereby the action systems needed to deal with threat (e.g., rage, freeze, hypervigilance) separate from each other. This may create multiple EPs (or parts) and is referred to as "secondary structural dissociation." Diagnostically, this could be described as complex PTSD or DDNEC (American Psychiatric Association, 2013). If, as time goes on, the individual is unable to cope adequately with life, the ANP (that part of the personality that is interacting with the non-trauma world) may divide. The individual then consists of two or more ANPs, each with its own set of EPs. This is known as "tertiary structural dissociation." Each ANP is considerably elaborate and is experienced, together with its own EPs, as separate from the other ANPs with their EPs. Tertiary structural dissociation presents as DID.

Structural dissociation differs from the ego-state model in the description of an ANP from which the EPs are split off as opposed to different ego-states (parts) that become more and more distant. Structural dissociation adds to our understanding by describing the dynamic that may be occurring when an individual (child or adult) moves from less severe dissociation (one ANP with one EP) to more extensive dissociation (one ANP with two or more EPs), and from what may be referred to as a DDNEC to DID (two or more ANPs with their own EPs). Based on Nijenhuis and van der Hart's further refinement of their model of dissociation (2011), only situations where the separated ANPs or EPs experience a first-person perspective can be referred to as a dissociative disorder. These theorists would place experiences such as depersonalization, derealization, or amnesia as not being dissociative disorders but rather as anxiety disorders

(Nijenhuis and van der Hart, 2011). There is considerable debate with regard to this restrictive definition of dissociation (see Commentaries, 2011).

When looking at treatment, van der Hart et al. (2006) recommend a three-stage model—stabilization/symptom reduction, treatment of traumatic memories, and personality integration/rehabilitation. The use of a three-stage model is not new (see Briere, 1992; Herman, 1992); however, the use of this model with an emphasis on which part of the action system or personality (ANP, EP) is being addressed adds to our thinking. Within the first stage of therapy, emphasis is placed on work with the ANP—establishing safety, simplifying daily life, setting limits on demanding relationships, and developing skills. Psychoeducation regarding dissociation and the complex system that has been established also occurs during this stage. The primary principle throughout the stabilization stage is the establishment of a positive therapeutic relationship enabling the individual to work through the fear (phobia) of attachment and the fear (phobia) of attachment loss. This positive relationship needs to be with each part of the system—that is, whatever ANPs exist and whatever EPs exist. During this first stage, abuse-distorted beliefs and cognitions, as well as fear of emotions and body sensation (the reasons why EPs split off), are addressed and worked through. The rejection and anger of the ANP toward the dissociated parts (EPs) need to be addressed in order that the child and parent can come to accept the EPs and recognize how important they were for the individual's survival. The ANP/EP model helps both therapists and parents grasp the reality of the dissociative child's world: the day-to-day part (ANP) lives in and can acknowledge a safe world while the split-off traumatized parts (EPs) do not know that the "now" world is safe. Safety information must be made available to the EPs if the child is to reach the point of being able to move to the second stage of therapy—trauma processing.

At that point, therapy can enter the second stage, that of processing trauma memories. In this stage, therapy addresses the EPs and the sharing of trauma memories with the ANPs. The third stage includes integration and the learning of skills—adaptive coping skills and the information that may have been missed during the times of dissociating.

Emphasis on a three-stage therapy is crucial for the child therapist. The major difference from working with adults is that the main attachment being developed needs to be, when possible, with the parent-figure. A therapist can serve as a transitional attachment object as a child works through fear and abuse-distorted beliefs (see Chapter 2), but in order to achieve healthy movement through trauma to integration and positive future relationships, the child needs to have a healthy attachment relationship with a parent- (birth, foster, adoptive) figure. The importance of psychoeducation for both the child and the parent is emphasized. The framework of structural dissociation is particularly useful in explaining

why a dissociated part (EP) may not know about the safety in which the child (the presenting ANP) is living—a concept that is often difficult for parents and other support individuals to understand. Passing the information about safety to all the parts of the self (all ANPs and concomitant EPs), as well as building the child's skill base and addressing abuse-distorted beliefs, can be achieved best when the therapist and parent-figure are working together (see Chapters 3, 4 and 6). As these issues are addressed, the child's personality system will become more stable and flexible, thus enabling therapy to move to the second stage. During the second stage of therapy, trauma memories are addressed. Cooperation of the parent-figure with the therapist and support of the child by the parent are essential during this stage (see Chapters 5 and 6). As with adults, the third stage emphasizes integration and the development of new coping skills.

Summary

The models described in this chapter are clearly not mutually exclusive. Rather, each offers a different perspective as to the mechanism by which dissociation occurs and how it then presents within an individual. Putnam (1997) described a conceptual model of brain development that is interrupted by trauma. Liotti (1999, 2009) described an attachment pattern shaped by inconsistent and disturbed parental interaction with the child which, in turn, creates within the child multiple internal models and a vulnerability to dissociation. Silberg (2013) considers the child's need/effort to avoid negative affect as the starting point of dissociation. To achieve this avoidance, the child develops dissociated behavior states, dissociated affect states, and, for some, dissociated identity states. The models developed by Watkins and Watkins (1979, 1993) and van der Hart et al. (2006) describe the child and adolescent who already developed a "self" or "personality" that is then overwhelmed by some event or events. In an effort to protect the self, the fear response and/or memories are separated (van der Hart et al., 2006) or walled off (Watkins and Watkins, 1979, 1993).

The therapeutic directives arising from each of these theories indicate considerable overlap. The neurobiological studies, the discrete behavioral state model, the structural dissociation model, and the affect avoidance model emphasize the importance of decreasing stress (establishing safety and teaching emotional regulation) as an initial stage in therapy. The role of attachment is emphasized by Schore (neurobiological study), by Liotti (disorganized attachment model), by Silberg (affect avoidance model), and by van der Hart et al. (structural dissociation model); it is also briefly referred to by Putnam (discrete behavioral model). Because Liotti's model focuses on attachment development, this model has great value in highlighting the importance of working with parents. Much of what is

discussed by the structural dissociation model as belonging to the first stage of therapy (safety, stabilization) needs to be done in conjunction with a parent-figure. The ego-state model (Watkins and Watkins, 1979, 1993) is often a useful and simplified way of explaining dissociation to children and parents.

Neurobiological studies emphasize the importance of becoming aware of emotions and body sensations. Awareness of disavowed affect, with body sensation often connected to affect, is at the very center of the affect avoidance model. Indeed, increased awareness plays an important role in the therapy described for each of the dissociation models discussed: the discrete behavioral model and the ego-state model emphasize communication and the building of linkages between states, the structural dissociation model and the affect avoidance model emphasize "the working through of the phobias for feelings, memories, sensations related to negative experiences" (in the language of structural dissociation), and "the movement toward accepting the negative affects and negative events" (in the language of affect avoidance). The importance of including an awareness of all parts, ego-states, feelings, sensations, and memories within the child is central to all the therapies.

Trauma processing is seen as an essential process not only in enabling the child to include these elements within the self, but also in gaining a positive sense of self and an ability to trust the world. In Brewin's neurobiological model of trauma memory (2005), early traumatic memories are viewed as being caught in implicit or situationally accessible memory. For the child therapist, this highlights the need to work initially with drawings, play, and movement (Chapman, 2014). Brewin (2005) described the movement of these memories to explicit or verbally accessible memory as an essential part of trauma processing. The child therapists can recognize and give words to trauma shown in drawings, play, and movement (Wieland, 1997).

Several of the differences between models are a result of the population on which the model is focused. Both Liotti and Silberg are focusing on children and seeking to understand dissociation from a developmental perspective. Putnam, whose work has focused primarily on adolescents and adults, is similarly concerned with understanding dissociation from a developmental perspective. While the ego-state model and the model of structural dissociation both talk about increasing complexity of dissociative states (ego-state: degree of permeability between ego-states; structural dissociation: primary—one ANP with one EP, secondary—one ANP with two or more EPs, and tertiary—two or more ANPs each with one or more EPs), they are focusing primarily on dissociation in adults.

The challenge for us as child therapists is to use these models in a way that assists us in our work with children and adolescents. To do this, we need to understand each of these models. We can then use the varied

frameworks to assist us in understanding what is happening for the child at a particular point, and what the child needs to help move him or her further in an understanding and acceptance of all aspects and experiences of the self. While one model can help us explain dissociation to a toddler or young child, another may be more helpful when talking with an adolescent or parent. While one model can help us grasp what is happening for a child with dissociative symptoms and suggest a way to decrease the child's need to dissociate, another model can help us understand the child with DID and suggest ways to access and address the parts holding the trauma experiences.

Being With the Child or Adolescent

In this chapter, dissociation and how it may present in a child were described. Possible neurobiological effects underlying dissociation were discussed, and five conceptual models of dissociation were presented along with how these models can direct therapists working with children or young adolescents.

It is now time to take a more direct look at therapy with children and adolescents who dissociate—what it is like to be in the room with the child or adolescent. The chapters ahead provide descriptions of the interactions between therapist and child or therapist and parent, together with the therapist's thoughts and struggles, as well as important references to the theory and research that informed each therapist's work. Rather than working from any one model of dissociation, the therapists' work is based on what was known about dissociation at the time they saw that particular child, along with their knowledge of trauma, child development, child psychopathology, and family systems.

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2 Dalma (4 to 7 Years Old)—"I've Got All My Sisters With Me"

Treatment of Dissociative Identity Disorder in a Sexually Abused Young Child

Sandra Baita

It was 1998 and I was a novice clinical psychologist working in the city of Buenos Aires, Argentina. Several years earlier, I had read and discussed *Childhood Antecedents of Multiple Personality* edited by Richard Kluft (1985) with my supervisor, who had had training in the United States. The book revealed an unknown world to me, something that no one had ever told me before in college. The linkage between trauma and dissociation made complete sense to me, but I had no experience in the area. I had no formal training in the field of dissociation. At the time I met Dalma, I had no support for working with dissociation—there were no therapists trained in childhood dissociation in Buenos Aires. Thus, when I saw Dalma for the first time, I had a few—but far too few—ideas of what was happening with her. This is the story of how a novice clinician with no local support worked with her first dissociative identity disorder (DID) case in childhood.

Dalma was 4 years old when she was referred to me by the family court because of a report of her father having sexually abused her. I had been asked to complete a psychological assessment of her and two of her siblings with regard to the allegation of sexual abuse. At the time of the first consultation, Dalma was living in foster care with her three siblings. The older half-sister, Cecilia (13 years old), had been living in foster care for the past two years because of an allegation of sexual abuse by the stepfather (Dalma's biological father). He had been found not guilty at the initial trial. Dalma (4 years old), José (9 years old), and Beatriz (2 years old) had been separated from both parents because of a new allegation based on physical signs of sexual abuse on all three children. Two days after the report, the father ran away and was not apprehended for several years.

Initially, the family court judge allowed restricted supervised visits by the mother in the foster-care setting. These visits were suspended when it was realized the mother was pressuring the daughters not to talk about

the abuse. Both parents were charged with participation in the abuse—the father for having committed sexual abuse against his children and the mother for having allowed the sexual abuse to happen. The mother, a severely traumatized woman, stated that she did not believe sexual abuse could have occurred (the same attitude she took with her older daughter's earlier statement). When confronted with the physical signs of the sexual abuse, she said they could have resulted from the forensic medical examination, an examination for which she was present. During the six years preceding the trial, we were convinced that the mother's statement was part of a legal strategy to defend her against the accusation. Only after the trial did we learn otherwise.

At the time the younger children were separated from their parents, none had made any verbal allegations of sexual abuse. Because the mother was uncooperative in the initial interviews, my first information about Dalma's life came from her older sister, Cecilia. Cecilia reported that Dalma was the favorite child of her father. Dalma's appearance was dramatically different than that of the rest of the family. She had a fair complexion and was blonde. Dalma was described as a beautiful girl, very sweet, and cute. The appearance of the other siblings was exactly the opposite: dark hair, dark skin, and dark eyes. What part of the family Dalma looked like I never did learn.

So, I started my contract to assess and then provide therapy for the three younger children. A colleague who was initially working with me on the case interviewed the mother, while I interviewed the oldest daughter and the foster-care staff before seeing the children. I also read the court files containing the initial report and the forensics medical examination report in order to have some historical and contextual background before meeting Dalma.

Assessment

At the time I treated Dalma, I was appointed by the court to assess child sexual abuse allegations. When I received a case from the court, my first step was to read all the files. This helped me know how the case came to be reported and what was done so far. Today, I am still involved with court cases but mainly as a therapist. When I receive a case now that has already been reported to the court, I ask the parents for permission to read the files for the same reasons I did when I was assessing children. Some colleagues choose not to do this because they do not want to be biased by the information gathered in the files. I do not share this position: I do not think therapy can be split off from court intervention. It is the job of the therapist to maintain balance between therapeutic work and court involvement.

Dalma's Real-World Family

Dalma's mother was raised in a rural town of Argentina by an emotionally unavailable mother and an abusive father. She was sexually abused by her brothers who were considerably older and she received no emotional support in her family. Dalma's mother grew up as a shy girl who was severely and repeatedly punished by her parents and older brothers (multiple forms of physical punishment, as well as being locked in a dark room outside the house and being left alone for hours). As an adolescent she fell in love with a casual boyfriend, became pregnant, and had her first child, Cecilia. Dalma's mother then moved to Buenos Aires to work—a very usual movement for disadvantaged people living in rural areas of the country—and left her newborn baby with her own (abusive) parents to raise. Over the years, the mother occasionally visited Cecilia, but it was not until eleven years later that she decided to bring her daughter to live with her, her new partner, and their two children, José (then 7 years old) and Dalma (then 2 years old).

Most of the information collected about the father came from the interviews with Cecilia, as he had run away. The mother was less cooperative regarding her husband. She said she had no knowledge about his infancy and adolescence other than the fact that he was born in a rural area, miles away from the big city, and had no contact with his family since she met him. From Cecilia, I came to know that Dalma's father was chronically unemployed because he would get in fights with his employers. As a result, the mother worked outside the home most of the day to support the family. The father was in charge of raising the children—feeding them, bathing and dressing them, and taking them to school. He used to keep them isolated from any contact with other children in the neighborhood. The father's violent and aggressive behavior with his neighbors intensified this isolation. There was no particular information about the father's relationship with the youngest girl, Beatriz. With José, the father was physically abusive (José was the only one in the whole family group who was physically battered by this man). With Dalma, the father would spend lots of time playing and taking naps with her.

Another interesting fact about this family was related to the children's names. Each time a child was born, the father inexplicably engaged in fights with his wife and would leave the house for days, or even weeks or months. The mother, alone and abandoned by her husband, chose the names of her children. When her husband returned later, he disliked the names and pressured the mother to change the names of each child as a proof of reconciliation. Thus, each child had an "official" name stated on personal identification and a "domestic" name used inside the family.

The only child about whom the mother disagreed on changing the name was Dalma. Dalma's name evidently reminded her of someone in her birth family, and she continued to call the girl Dalma while the father called her

Debora. Thus, this little girl was the only one in the family who was known by two different names *inside* the home.

> This is a very usual practice in Argentina, especially among people from lower income sections of the society. Within most situations, it would not become a "risk factor" for developing a dissociative disorder. It was the dysfunction within this family and the way the names were used that caused it to become part of the dissociative system and became crucial in the discovery of Dalma's dissociative disorder.

Introducing Dalma

Because of the protective measures ordered by the family judge for the older sister, Cecilia, the court social worker went for a routine visit to the day care center attended by the little sisters, Dalma and Beatriz. When the court worker arrived, a terrible scene was happening. One of the assistants told her that while diapering little Beatriz she noticed bruises on the legs near the genitalia, and found blood in the vaginal orifice. The judge was immediately informed about this situation. He ordered a forensic medical evaluation of both the girls and the brother. The mother was also notified and accompanied her children during the medical examinations. The physical findings (as noted above on p. 41 and p. 42) were conclusive of sexual abuse for the three children. The mother, together with the children, was immediately referred to the family court. The same day, the court placed the three children in the foster-care setting where the older child, Cecilia, was living.

When the mother was told by the judge that her children would be placed in foster care, she started screaming and yelling so desperately that it was necessary for a police officer to intervene to calm her down. The judge took the children, scared and screaming, into his office and shut the door. At the moment the door was locked, the children immediately calmed down, accepted the cookies they were offered, took paper and crayons, and started drawing *as if nothing had happened*. The most horrible part of this for those who observed was not the screaming and yelling, which often happens, but the blank and numbed expression of these children who crossed the line between desperation and "nothing" in just a few seconds.

At the first consultation, the foster family reported Dalma had perplexing forgetfulness of routine daily activities (e.g., she would forget she had breakfast just a few minutes after having eaten it), often showed trance-like states, and demonstrated regressive behaviors both in foster care and at school (sucking her finger, rocking, talking babyish).

During our first encounters, Dalma denied her current reality. She kept telling me she was living with her parents, yet at the same time, she was completely unable to recall her father's name. Dalma avoided eye contact

and was unable to answer simple, apparently non-conflictual, questions about the family: "What is your house like?", "Do you have a puppet?", "Which is your favorite toy?" Later, when questions about abuse were asked, she stared as if in a trance, started rocking, and was unresponsive to any environmental stimulus. At times, she would suddenly come out of this state and continue doing whatever activity she had been doing before. Her play was quite disorganized and often accompanied by incomprehensible baby talk. The human figure drawings (Koppitz, 1968) showed inconsistencies not related to any developmental difficulty. Most of her human figure drawings completed during this first assessment interview looked like little robots (see Figure 2.1), and all of them had things coming out of the head. When asked about these details, Dalma was unable to explain anything.

It was puzzling to me to see how this girl presented even knowing she had gone through such a traumatic situation. She insisted on numerous contradictions—she was not living with her parents, but she said she did. Her mother visited her once a week for an hour, but Dalma talked about doing activities with mother as if she were living with her. Dalma stated no memory of any abusive behavior. She did not even recall having been seen by doctors who checked her private parts.

> Alterations in consciousness and memory are one of the core symptoms experienced by children exposed to chronic traumatization (Stien and Kendall, 2004). With these contradictions between what Dalma "pretended" to be living and what she was actually living, Dalma showed the exact spirit of dissociation: her need to back off all her traumatic memories as if nothing like this had ever happened to her. For those who have to live facing life threats, a significant narrowing of consciousness can be expected, so the person can focus just on the central perceptual details (Christianson, 1984, cited in van der Kolk et al., 1996). In the case of severe and chronic traumatization, this partial focus of attention can serve as a way to escape from the overwhelming reality of the experience (Siegel, 1999). Whenever traumatization continues, as in cases of child sexual abuse, the narrowing of consciousness can evolve into a complete amnesia of the experience (van der Kolk et al., 1996).

Based on the different names used within the family, I decided to make a little change during one of the assessment sessions. Even though I had asked her name during our first encounter and, from the very first time, she said she was Dalma, one day I decided to ask if *Debora* might have any information about things that happened with Daddy. After my question, "I wonder if Debora knows something about the things that happened with Daddy?" the girl, silently and calmly, used little dolls to



Figure 2.1 Human figure drawing with objects coming out of head. (Used with permission.)

show me a scene in the bathroom of the dollhouse where a daddy was on top of a little girl and the little boy doll was staring at them. She repeated this scene over and over again.

> My decision to use the different name was based on the importance of using the language that is most familiar to the child, and this would include her name. Because Dalma's father called her Debora, this was language familiar to her and, in particular, familiar to the father–daughter experience. This simple question and the child's answers to the subsequent questions clarified Dalma's dissociative disorder.

> Debora's attributes started to appear. She was 3 years old and did not talk. Her function seemed to be that of watching everything Daddy used to do to Dalma. She was the one who could show the abuse but could not talk about it. It was obvious to me that she was unable to verbally express what had happened to her because she was little and did not yet have clear language. The baby talk I had heard from Dalma was coming from this dissociated part named Debora, the one in charge of holding the terrible secret of sexual abuse.

After the play scenario described above, I asked if she would be willing to draw Debora (Figure 2.2).

The biggest figure, empty eyes, on the left, is Debora. Dalma told me to write, "She's looking at what I'm doing." The girl in the right part of the drawing is Dalma, who is "doing some things with mommy." Even if Dalma did not talk about the abuse situation in this drawing, the observer condition of Debora was clear with the drawing and the play described above. This play moved to a more active representation of the situation in later sessions.

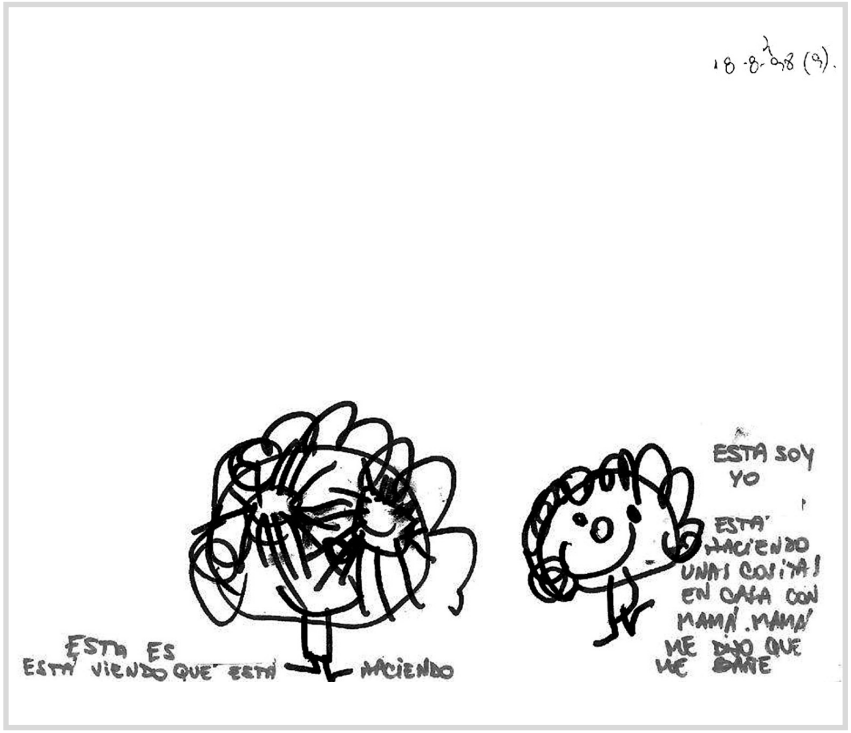


Figure 2.2 Debora and Dalma. (Used with permission.)

The Treatment

Following the assessment, both Dalma and her brother José started weekly therapy sessions with me. They came to my office on the same day but were seen separately. A person from the foster-care staff would come with them, usually reporting the most salient facts of the week. The treatment lasted for almost three years, until the foster home had to suspend the therapy with me due to lack of funds. The children then continued treatment with two therapists who were part of the staff of the foster placement program. With the father vanished, the criminal court could not prosecute and the family court judge was reluctant to make any major modification of the status of life for these children. They were well cared for physically and emotionally at the foster home, they socialized with other children, they went to school, and they had learning support when needed. The children felt *this* was their home. And for the judge, it looked like a good living situation for them, so he was in no hurry to make any kind of change.

I will describe how the treatment of Dalma went through three different phases during those three years. These phases do not relate to what trauma therapists know as "stages" of treatment—stabilization and safety, symptom reduction and trauma work, and resolution and integration of traumatic memories (Herman, 1997; Putnam, 1989; Silberg, 1998; van der Hart et al., 2006; van der Kolk et al., 1996) but, rather, to the *contextual factors* that influenced the course of treatment for this girl. These contextual factors were mostly related to the family court decisions regarding the contact of the mother with her children. The attitude of this mother toward the sexual abuse of her children and how her personal life during these three years evolved could be seen as retraumatizing factors.

First Phase of Treatment: Dalma and Her Sisters

During the beginning part of treatment, which lasted almost an entire year, Dalma and her siblings had no contact with their mother. Given the results of the assessment, which were conclusive and supported the medical findings regarding sexual abuse, the judge decided not to make any change in the situation of no contact with the mother until she could prove that she was, at least, undergoing psychotherapy. The restriction of contact also included phone calls.

The absence of the mother and the adaptation to the new foster home helped Dalma's behavior stabilize. She was living in a predictable environment, and far from any risk of further victimization. At this point, she was able to show through play little parts of her fragmented memories: once again, there was a little boy spying on his father when he was in the bathroom on top of a little girl, but this time she added a mom to the scene. The mom in the play could be good, caring, and protective to

her children, giving them all they wanted and, at other times, mad, grounding the children, and yelling at them, while centered on her own activities. One day, I asked Dalma if she knew when this mom was good and when was she bad. She was clear: Mom was good and caring and affectionate to Debora but was angry at Dalma. Then, suddenly, she said, "I guess there are two Dalmas, one is Dalma, and the other one is Debora, they are both the same . . . but in different colors." When I asked Dalma what this was like, being the same but different in color, she drew a picture (Figure 2.3). The left side of the head with hair and the right side of the body were orange; the right side of the head and the left side of the body with the long arm were green. I told her I understood that they both shared the same body, so they were not exactly different persons.

> It was clear for me that Dalma was trying to make sense of her internal experience, using her own resources and language. She might not have been able to say how odd it was to feel that there were two girls inside of her; she just drew it.

After this session, Dalma appeared to recover many of her memories of the abuse. She told me how her father hurt her private parts and confirmed that her brother knew and saw sometimes what their dad did to her. The telling of the memories came bit by bit. From this moment, the word *hurt*, used either by her or by me, would act as a trigger for Debora, and she would create a dramatic reenactment of sexualized behaviors in session. The behavioral and somatic memory of the abuse was held in Debora, and the reenactment was the body's way of talking.

> Memory studies suggest that under traumatic situations the experience is mainly implicitly encoded (Siegel, 1999). This explains why the traumatic event can be fragmentarily re-experienced as smells, sounds, behaviors, visual images, and kinesthetic sensations (Siegel, 1999; van der Kolk et al., 1996). It is suggested that somatic memories can be considered as evidence of physiological arousal associated to the trauma (van der Kolk et al., 1996). This seemed to be the case with Dalma, as she used the sexualized behaviors to discharge the arousal being recalled.

The first time I saw the dramatic instant display of the sexual and primitive behaviors of a little girl moaning while rubbing her body on the sofa, I was astonished. How should I intervene? Should I ask what she was doing? Should I ask who was there? Should I stop her behavior? Should I distract her while ignoring what was going on?



Figure 2.3 Both the same but different. (Used with permission.)

After the first few seconds of my own shock, I decided to talk to her in a soft tone of voice telling her that she was OK *now*, that she was in a safe place *now*, that she was with me *now*, and repeated my name to her while Dalma moved from the sofa to under the table, still hiding for a few more seconds, while spying on me, and then came out, sat quietly, and, in silence, kept playing.

> It was important for her that I was consistent in reassuring her about the safe conditions of this current situation. She was re-experiencing a part of her trauma. There was no room for any kind of questioning or interpretations, or for waiting to see what would happen. What I did was just to calm the system down, reassure the child, and let her feel and experience the safety

I was talking about. If the therapist is not attuned to the emotional state and arousal of the child, there is the chance the child will be retraumatized as the therapeutic setting starts to resemble the traumatic situation. This is the reason why stabilization and safety always come first in the treatment of traumatized clients (ISSTD, 2004, 2005; Silberg, 1998). Dissociative parts hold memories of the past, whether as images, behaviors, emotions, or a fragment of knowledge about what happened as if in present tense, even though the abuse or trauma is over. No matter how fascinated (or frightened or astonished) we are by the switch between parts, we always have to keep in mind that this part is somehow stuck in the past, and the only way to work toward integration is to start teaching this part that the past is over and safety now exists.

What I did at this moment was reorient her to the present: the part who was acting this sexualized scenario was reliving it as if past time had suddenly become present. But her real actual present was in a foster home, living with people who cared for her. And it was important for her to be aware that the source of danger was no longer part of her life. This was the reason for the particular words I used.

Because Debora did not talk, it was impossible to address any issue with that part of Dalma. Sometimes, Dalma would act like an interpreter and tell me some things about Debora, things that seemed to have some relationship with the abusive dynamics: "Debora is sleeping with a man because she likes it, and Mom lets her do it." If I went further with questions related to these statements, the dissociated sexualized behaviors would be triggered.

It could be very confusing—I would be in front of a little girl who played a scenario from her life (a child sleeping with a man), and then she would suddenly jump to another scene (a judge yelling at a mom who said "I was shopping;" a judge accusing a mom of having left her children alone). There would be no explanation with these changes.

What triggered her switch? At this point, I felt almost as if every word, every move, and every gesture of mine could potentially act as a trigger. It looked like a puzzle where some pieces had been lost.

One day Dalma came into my office saying "Did I tell you that I have more sisters?"

I knew she had more sisters, Beatriz and Cecilia were both living with her. I wondered if she was coming out of a memory gap and did not realize I knew about her sisters.

> Instead of imposing my hypothesis on the treatment, I decided to see where a simple question could take us both.

I said to her, "Could you please tell me more about them?"

And this is how Dalma started her explanation: "One of them is Mary, she's older, and she helps Mom, the other one doesn't have a name, well . . . I'll name her Nada, she's younger than me" ("Nada" in the Spanish language means "nothing"). I asked Dalma if any of these sisters knew what had happened to her, what daddy did to her. Dalma, upset, said, "Yes, Nada was there, she was playing with my toys, Daddy knew she was there, and she saw the things Daddy was doing." I asked if she had ever told anybody about what was going on. "No, never. . . . There is another one, Lily, she's younger too, I don't want to draw Nada, she's mean, she beats me, she's home with my mom now."

I reassured her that she was not living with her mom, and that she could feel safe. Dalma got closer and said, "OK, but let's talk quietly, she might be listening anyway." I asked Dalma if the other sisters, especially Mary, who was older, could help her; she agreed and asked me, "Talk to Mary and ask her to tell Nada I don't want her to beat me anymore." Which, of course, I did. But then Dalma went back to her lonely play and did not interact with me anymore during this session.

Even though I suspected that these *sisters* were dissociative parts of Dalma, as Debora was, I had to check if there was any kind of connection with real people. She was living in foster care, sharing space and time with other children, and spending time with other adults who took care of her and her siblings. So, I did my own research. Did any of the girls in her foster home have this name or age? No. Actually, Dalma said they *did* live with her, but there were no girls with these names at the same foster place, and there were no known relatives (grandma, aunt, cousin) with these names. Could this be a memory of someone she knew in the past? Maybe a former friend she knew at the day care center? No people with these names or ages were found. Actually, during the next session Dalma was very confusing regarding which of these *sisters* lived with her in foster care and which were living with her mom; sometimes she would say that they were both living with her *and* with her mom. Despite this confusion regarding some aspects of these dissociative parts, it was clear that each part was in charge of keeping different information regarding Dalma's life.

At the next session, I decided to address the sisters issue again. Our previous conversation was interrupted by the anxiety triggered by Nada's appearance. To start this new conversation, I asked Dalma to draw a picture of her sisters.

She introduced her sisters to me with a drawing (see Figure 2.4). On the bottom left is Dalma; top left, Lily, 3 years old; bigger figure at the

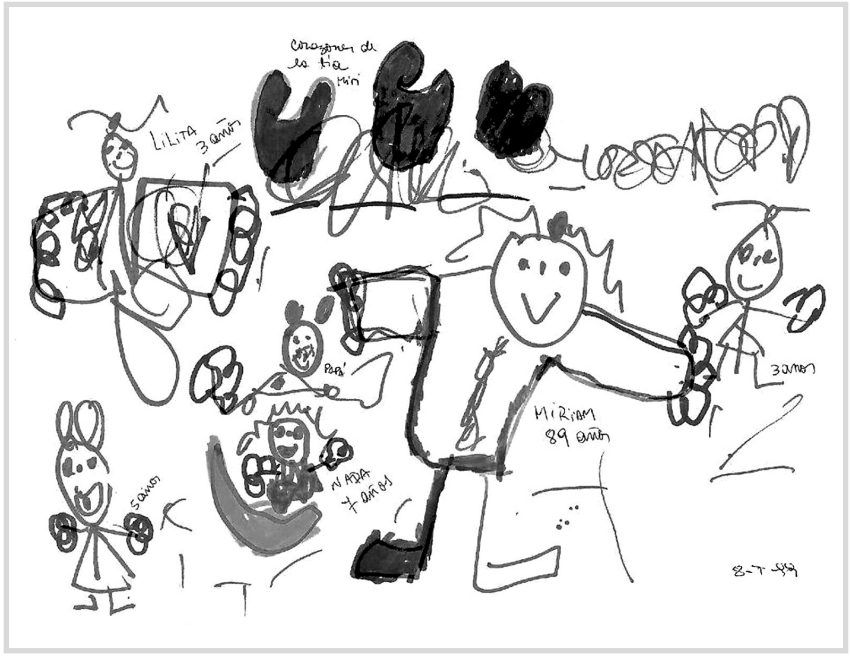


Figure 2.4 Dalma and her "sisters." (Used with permission.)

center, Mary, 89 years old; right side, alone, Debora, 3 years old; bottom, Nada, 7 years old; and above, Nada, Dad. Three hearts are at the top.

In this drawing, Dalma showed her complete internal dissociative system to me. She said, "Nada is really angry, she's mad at Daddy, she doesn't want to take a bath with him. Mary is the older one, she's older like a grandma, she's 89, Lily is the best, she's really good, not like Nada, she's the worst. Daddy used to touch Debora's private parts in a room, and Dalma saw this, Beatriz too." As she referred to Dalma in the third person, I assumed that there might be another part talking, so I asked who was the one talking? She skipped the question and kept saying: "Debora said, 'Please don't do this anymore,' and Daddy would say 'I won't, I promise, can you forgive me?' And Debora always forgave him."

I asked, "And what can you tell me about the others? Were there any of the others who won't forgive Daddy?"

"Yes, Nada didn't want to forgive Daddy, she said she would take a bath with Mom, not with him. Do you know? Lily and Debora are both the same age, but they are really different."

"How is that?"

"Lily wants to go sleep with me, she says she's scared, because Debora uses a mask, she has clown masks and cat masks too."

"And what does Debora have these masks for?"

"These are not hers, are Daddy's masks, he loaned her some of his masks, he used the masks for scare all of us at night, Beatriz was there too."

"Who did Daddy scare with his masks?"

"Me, and Nada was scared too, and Mary too, she screamed 'Mommy help me,' but Mom didn't listen to her, but she insisted, and went for her mom and said 'Mommy he's touching me on my pajamas,' and Mommy said she would ground Daddy."

This last statement seemed to be consistent with some things her older brother José told me about his mother knowing what the father was doing and his mother telling him she would call the police.

> With these little pieces of information, I could start to understand who, or what dissociated part, might appear in my office. The puzzling presentation of this child was clearly a picture of her real experience—an experience of confusion, terror, and uncertainty. How could anybody even imagine that being sexually abused by a dad is harmless?

At this first part of treatment, this is the information I had:

Debora: She was a sort of *observer*. She was the one who held a somatic memory of the sexual abuse and enacted it during play. She was 3 years old, barely talked, and showed very regressed behavior.

Lily: She was 3 years old as well but, unlike Debora, she held memories of the type of care and nurturance a child this age needs. She behaved like a 3-year-old, like Debora, but without sexualized content in her behavior.

Nada: She was seen by Dalma as the hostile one. Dalma was scared of her and said Nada would bite her and scratch her. But Nada was also the one who could reject daddy's sexual requests. Most of the time, she had no face on the drawings.

Mary: She represented a protector part and was 89 years old. This part provided the nurturing and caring a little child needs. Sometimes, Dalma would say she was an aunt or a grandma.

The challenge was determining whether these were dissociated parts (alters) of Dalma or products of her fantasy.

> It is not an easy task to define briefly what an "alter" or dissociated part of the personality is. Let's say that it is a holder of specific memories and related feelings, sensations, beliefs, and knowledge, of the experience. This information network was disaggregated from other networks of information. According to van der Hart et al. (2006) and Nijenhuis and van

der Hart (2011), dissociation can be understood as an integrative failure. Inability to integrate experiences fully (as in the case for young children whose integrative capacities are still developing) and early trauma in the context of interpersonal relationships (i.e., attachment system) seem to be major contributors to this integrative failure. Following Liotti's (1999, 2009) thoughts, the disaggregation of information networks—dissociation—should be considered the very consequence of trauma, rather than active defense against its consequences. However, clinicians have traditionally referred to dissociation as a way to protect the child from facing the entire picture of the traumatic experience. I personally consider that both views can coexist, since the final product in the subjective experience of clients of all ages is protection from pain, and this is an explanation of dissociation children can understand. Dissociated parts or alters have a job, as I like to say to my little clients. Some of them may carry the hostile and aggressive feelings, sensations, and behaviors that the child thinks or believes he or she might have used to stop the abuse if possible. Some others may be protectors or helpers to whom the child would turn in the face of the traumatic experience. Various functions for the dissociated parts or alters have been described in the literature. The most important thing for the clinician to understand is that, without an adequate identification of the personality system (Silberg, 1998), you will only work partially, with only one aspect (feeling, memory, sensation) of the whole experience, and you will not be able to progress into any trauma resolution. For more elaborated explanations of what an alter is and how to identify dissociated parts of the personality, I refer the reader to Putnam (1989), Shirar (1996), Silberg (1998), and van der Hart et al. (2006).

A few weeks after mapping the system, Dalma entered my office and looked like a completely different child. Unlike other sessions in which she had immediately engaged in some sort of play, or sat at the table and started drawing, Dalma was very quiet and looked all around as if it were the first time she had entered this room. She looked withdrawn when she started putting the small dolls inside a house. I asked her who they were. She said, "The mom, the grandpa, an uncle, an aunt, and Lily." She had a tiny, babyish voice, her sentences were not well articulated, and she did not talk spontaneously but only responded to questions. When I asked her for Dalma, she said she did not know who Dalma was. I asked her about the other sisters, and she said she only knew Debora and Nada because they had told her their names. Then I encouraged her to introduce herself, and she said she was "Lily."

Mapping the system was developed as a therapeutic technique to identify the parts of the personality in clients with DID. It helps to identify not only the parts, but also how the client sees and feels about each of these parts, and how they relate—or do not relate—to each other (Putnam, 1989). For children, the creativity of the therapist is the only limit to helping the child map his or her system. You can use toys or other figures to represent the internal system. I like to take a picture of what the child has drawn or the scene created with toys so we can keep it for later work. One thing I have found children like very much is Russian dolls (the ones that have many dolls, one inside the other). In the case of Dalma, Figure 2.4 is her first mapping of the system.

I asked her if she knew who I was, and "Lily" said she did not, and she did not know the place (office) either. "Lily" said this was her first time in the office and she came because she had been told to come. When I asked her who told her to come, she said it was the lady outside. "So you came here with José?" I said, as her brother was coming at the same time for his therapy sessions. "Lily" said she did not know José. After my questioning about Beatriz, she said she did not know her either.

The Lily part was initially unable to engage in any kind of play. She was quiet and unresponsive. Then, all of a sudden, she started to play, taking a little Playmobil® girl and placing her in the middle of the other toys, dinosaurs, and superheroes. I asked her what they were doing. With a vital and self-confident voice, she replied, "They're watching." "What are they watching?" I asked. But she gave no answer.

I noticed the clear change in her mood—from being quiet and almost lost in the office to very active and engaging in play, and the way in which she modulated her voice—from shy, almost whispering, to vital. I decided to ask to whom I was talking. And she said, "It's me, Dalma."

Sometimes therapists need to act as detectives. Changes in voice or mood can be quite subtle, and we need to develop our observational skills in order not to miss any change. Otherwise, we could be losing important information of what is going on in the internal system of the child. The therapist must be attuned to the sometimes subtle changes of the child in order to understand which part is taking control. Each part holds different information, and if we are not sensitive to the changes and presentations of the different parts or alters, we will fail to address key parts of the child's life and experience. If we do not address this, we will be unable to promote any change in the dissociated world of our children and will somehow contribute to sustaining the dissociative functioning.

The presentation of this internal dissociated system not only allowed me to know the fragmented parts of Dalma's memories and experiences, but also helped her to get in contact with these memories and experiences, including those related to the absence of her mom, and the reason for this absence.

During the next sessions, Dalma spontaneously kept drawing her internal family, all together, even if some of them did not yet know the others. In one picture, Dalma drew herself holding hands with her "sisters" and created four beds, one for each of them, including one bed for mother. As I noticed that three of them had their faces crossed out, while two had their faces clean, I asked Dalma what this meant. She replied, "Debora is the only one who can see; Nada is so mean, she's really bad, and she was daddy's favorite girl." She again became very upset and anxious, the same reaction she had shown previously when talking about this dissociated part named Nada. For this reason, I suggested she create a little house to keep Nada inside whenever Dalma wanted to talk to me without Nada listening. Dalma decided to add another bed and said, "She can stay here for now. Did you know? I've got a dream of my mom, I was with her at home. Is she going to see a therapist too? Why can't she see us? Is she with my dad?" Then suddenly she said, "I used to pee my bed at night, my mom would wake me up and tell me not to do this anymore, and after that she brought me to take a bath." I asked if her daddy ever bathed her: "No, not me, but my sisters."

The concept of containment is very important in the therapeutic process of clients with DID (Adler-Tapia and Settle, 2008; Turkus and Kahler, 2006). When facing the information held by the different parts, the child may feel overwhelmed and flooded by intense waves of feelings and memories that dissociation had been keeping away. If the therapist fails to help the child contain these feelings, memories, and sensations (to pace the way in which he or she is facing them), there is the risk of retraumatizing the child and pushing the child into more dissociation. Containment techniques can also be used to keep the youngest and more vulnerable parts safe, to keep hostile parts (such as those identified with the abuser) aside while other parts of the child are talking about the abuse, and so forth. The therapist can use objects to resemble a container (such as a box), drawings, or visualization. The important thing is to be sure that the child experiences the containment as effective.

The option of creating a bed for this hostile part shows both the acceptance of Nada as part of herself, and an enhanced control over the fear and anxiety triggered by the appearance of this part. From this moment

on, Nada will never show herself as a part who threatens Dalma or any other of the sisters. This shift is very important in the treatment of dissociative individuals, both adults and children, as it indicates more internal communication and cooperation between parts, an important step in the process toward integration.

At this point in treatment, Dalma would, with her play, provide more information about the memories held by her dissociated parts. These play scenarios allowed her to ask questions, and to process difficult and painful situations. Some of these play scenarios seemed to be started by memories that came out of the blue in small but significant pieces:

> I used to sleep with Beatriz on the same bed, and she was freezing, so I told her to cover herself. Storms scare me a lot and I have to cover myself too. And I remember my mom brought us to a place where there were doctors, it was when I was hurt.

When I asked what else she remembered, there was no answer.

Therapists need to be cautious and keep balance between their interventions and the things they think they need to know. I guess it was somehow my own curiosity and anxiety that made me jump into this question. Although Dalma's later play showed the processing of some of her memories, a better intervention would have been to be more empathetic with her memories, something like "I'm so sorry you had to go through all of this. Maybe there might be some other things you want to share with me about what happened?" This is a way in which the therapist shows respect for the child's experiences while also encouraging the child to talk without pressure. When we ask a child something in a more direct manner, the child may feel pushed to answer something and, if this is something of traumatic content, may feel safer turning to what the child knows better, such as dissociation. Besides that, we should bear in mind the fact that, when working with dissociative clients, we are talking to an entire dissociative system, and we cannot assume that all the parts would agree on answering a particular question. What might be known for one part might be unknown or painful for another; what might be important to say for one part might be a secret to be kept for another. If we do not keep in mind these sorts of internal boundaries, what pretends to be a dialogue can easily turn into silence and doors shut within the system.

Silberg's Affect Avoidance Theory (2013) provides an insightful explanation to this: dissociation implies a pattern of affect avoidance which generalizes to avoidance of memories, sensations, pain, and experiences

related to the affect. I thought that the fact that Dalma was sharing some of her memories with me was a signal that I could move forward and keep asking. But dissociated memories, affects, experiences and sensations do not come out in a linear way, neither do they come out to satisfy a therapist's curiosity. In Silberg's own words: "Affects are like the road signs of the self's navigational system. . . . For the dissociative child, the navigational system is turned off and autopilot programs, responding to only partial information, control behavior" (Silberg, 2013: 21) With my question, I was pushing Dalma into more deeper, painful memories, whose related affect was so pervasive that the "autopilot program" of shutting down was triggered.

I am currently in the process of understanding how the theory of structural dissociation of personality can inform child therapists about dissociation in children. Van der Hart et al. (2006) state that, even when danger is over, the dissociative structure developed to deal with danger is sustained by conditioned avoidance (phobia) of different contents related to their traumatic experiences, both internal experiences (such as the experience of affect, dissociative parts of the personality, traumatic memories—as seemed to be the case in the last vignette of Dalma's story, attachment and attachment loss), and external experiences (such as any external stimuli that might trigger traumatic memories). In line with the three-stage model of therapeutics, a recommended progressive approach of treatment implies working through these phobias during all stages of therapy (Gonzalez and Mosquera, 2012; van der Hart et al., 2006). It is inevitable for me to think how much more organized my work with Dalma could have been had all these ideas been available then.

Then she started a play reenactment of the experiences in court. This reenactment was different in that, unlike the earlier court play scenarios, she interacted with me rather than leaving me aside. After placing some of the dolls as if they were being confronted, she said with a very strong, hard voice, "These are my kids. They have been touched. It wasn't the father."

Acting within the play, I said, "But the kids told me it was the father."

Dalma did not assign me any specific doll or character to represent. I had not specifically planned to intervene this way. Was it the part of me who wanted the truth to be known that came out?

"You're right," Dalma said to me. "Get out of here!" she said to a female doll, who may have been representing the mother. "You're right, Sandra, you and the judge." Then Dalma engaged in a sort of dialogue between a

man and a woman. In a man's voice, she said, "Who are you?" In a woman's angry voice, she said, "Let me see! I want to see!" In a man's voice, "You can't see anything, it's forbidden." In a woman's voice, "But I haven't seen anything!"

> It seemed that my place in the play was that of the witness.

After this play scenario, Dalma asked me to show her all the drawings she had done of her *sisters*. She told me that the only person who knew about her internal *sisters* besides myself was her real sister Beatriz, the one who was waiting for her outside my office.

As Dalma showed more stability when addressing issues related to her internal system, it was possible to start educating her about her dissociative processes. I explained to Dalma that each of these *sisters* was a little part of herself holding some information or memories about her life with mom and dad before she entered foster care, and the things that happened when they all lived together. I told her that sometimes when scary and confusing things happen, our brain comes to help us so we do not have to pay attention to these awful things that are going on. To help me in this explanation, I used her own drawings, the ones she asked me to see again.

> Psychoeducation is an important part of the first stage of treatment. Children can learn that the things that happen within them, including the manifestations that might make feel them odd, are different aspects of a complex and amazing survival strategy. They also need to know that when the reasons that gave birth to this strategy are no longer present in their lives, dissociation and dissociated parts might become more of an obstacle than a helper in their daily lives. For this reason, it is so important for them to learn new strategies to deal with difficult situations. Psychoeducation can help the child know his or her internal parts, understand their function, learn how to communicate with them, and create a pathway for working through the awareness of each part, thereby allowing co-consciousness to happen.
>
> Parents, teachers, and foster-care workers must also be taught about dissociation and its manifestations in the child so they can help the child and cooperate with the therapy process. Psychoeducation can help the family and adults surrounding the child understand how he or she dealt with the traumatic situation, and recognize which stimuli, even neutral-appearing stimuli, might trigger dissociated parts or manifestations.

Following that, Dalma was more willing to tell me about the presence of her other parts whenever they would present in my office. She was willing to share with me their feelings, sensations, and memories, as well.

At this point in her play, Dalma was playing out fragmented memories such as being tied up by the father and crying for help with nobody answering. Dalma then started a series of play scenarios in which there were two different moms: one of them was capable of sacrificing her children, she would abandon them and not care about them; the other one was caring and loving, she would take care of the children's daily activities and needs. The latter was exactly the experience Dalma was having in foster care. She and her siblings were fed, dressed, warmed, comforted, and educated with genuine interest. Even if the foster-care setting was full of other children similar to her, the organization of the place included a number of adults, each of whom had a task to accomplish. Children were not grounded for playing with other children, or isolated from the outside world, as had happened in her birth home. The children were taken to the doctor, to the dentist, to school, and to the therapist whenever necessary. There was a routine, and there was stability. Nobody hurt them. This consistent, stable, and safe experience let the part Dalma named Mary integrate.

> For Dalma, the real and concrete experience of being cared for by an adult nurturing person could repair the internal need for help (resulting from her birth mother's lack of caring) that had led to the creation of Mary. The fact that Dalma was not in contact with her mom might have helped her anchor to the foster experience of nurturance and care.

Over the last months of the first part of treatment, the play evolved and included the figure of the judge claiming he would protect the children against the "bad father." As Dalma, at this point, refused to let me participate in her play, my interventions were limited to making links and connections between the play material and the things we knew had happened in her real world (e.g., the participation of a judge to protect her and her siblings from the abuse).

During one session, Dalma took one of the dolls and engaged in a sort of fight against the judge (another doll).

Taking the female doll, she said, "I'm so sorry, I haven't seen anybody touching my kids' parts. It wasn't the father, maybe they were other kids, not mine."

So, I replied, "But the kids said the dad did touch them. And the judge knows that."

"OK, Sandra, you're right, you and the judge, too. But the judge is the one who knows the most (taking the male doll and changing the voice, angry) 'Who are you?' (Changes the voice again to a different one) 'Please, don't shut the door, we haven't seen anything, we want to listen to what you say with Mom.'"

I then replied that it seemed to me that the kids were very worried and sad.

Dalma looked at me and with the same last voice said, "The judge is so bad. He took us away." After that she took the female doll who—with an angry voice—whispered, "Shut up, you don't have to talk anymore."

I responded, "It's very difficult for the kids. They had been hurt and they want to tell, but the mother tells them not to. I guess the judge had realized that and maybe this is the reason why he took the kids away. To protect them so they can feel safe and talk about what happened."

Dalma talked to me in a soft voice, not angry, not sad, "The kids are tired, they will go to bed. Can the judge go to bed with them, too?"

And I said, "No, he can't do so, but maybe he can send the kids to a safe house in which other adults can take good care of them."

A good intervention here would have been to explain to Dalma why the judge was not allowed to share a bed with children. This would have helped her education regarding physical and personal boundaries, an issue that sexual abuse helps to erase. At each moment, as therapists, we do the best we can, but then we can learn from what we wish we had said.

To what I suggested, Dalma said, "Yes! Is he going to fight with us? We will stay awake so we can fight against the bad dad."

By the end of the first part of the treatment, co-consciousness increased. Dalma was able to be fully present while her other parts shared information about their own experiences, and she could feel more in control of her behaviors in the therapeutic setting. There was no longer the splitting into chaotic or sexualized behaviors. Dalma also was able to listen to and believe her internal sisters' accounts. Even if she could not say that those things happened to her, she was able to acknowledge that the story was real.

Outside the therapeutic setting, Dalma's odd and regressive behaviors had mostly disappeared.

In the field of dissociative disorders, we refer to co-consciousness as the internal awareness of the existence of the other parts, and of one's own experiences, actions, feelings, thoughts, and perceptions (Kluft, 1984; Turkus and Kahler, 2006). The development of co-consciousness is important for internal communication and cooperation to happen. By helping to make connections between information networks that are completely disconnected (dissociated), the amnestic barriers become more permeable, allowing a fluid and constant work toward integration (Gonzalez Vazquez

and Baita, 2008). The development of coonsciousness starts during the first stage of treatment as the therapist and adult or child client are able to know the internal dissociative system (Silberg, 1998).

Second Phase of Treatment: Mom Is Back Again

Almost an entire year had passed since the mother had temporarily lost her right to visit her children. She entered therapy a few months after the restriction order and subsequently started asserting her claim for her children. Her therapist supported the mother's claim in front of the judge. As the court was reluctant to give the mom unsupervised visits, the judge said he would allow these visits only if they took place within a therapeutic context. Family therapy was planned to start with both the mother's therapist and myself.

Serving both as the individual therapist and the family therapist is not an ideal situation. The lack of trained professionals in the field of sexual abuse in the city at that point, and the trust the court had in our experience (both mine and my colleague's) were the main reasons for this therapeutic format.

It was clear to me that the three children would need some kind of preparation before seeing their mom again. They had not heard anything about her for an entire year. In addition, the mom was living with a new partner and she was seven months pregnant.

There were two initial purposes for this family therapy. The first was to address the whole situation that had led to the separation within the family: why the children were in foster care, why the mother had not been allowed to see them for such a long time, and why access was allowed now only within these therapeutic conditions. The second purpose was to continue assessing how engaged the mother was in her protective role with her children—how much she had learned and processed within her own therapy work. Mother's therapy had lasted only six months and had ended because her therapist had no more appointments available. What was the mom's present attitude toward the abuse? Did she believe her children? How would she explain her new marriage and pregnancy to her kids? Was there any sign that she was being protective of the abuser? Was she willing to talk about her new husband? Did the new husband know anything about the abuse? And what was his attitude toward the situation?

In the end, there were many questions but no certainties. The criminal court was paralyzed in its actions because the father continued to be a

fugitive. The family court would not make a decision about the mother until the criminal court case was completed. This was the context within which the second part of treatment occurred. This part of the treatment lasted almost eight months.

It was time to start talking about the future meeting with her mom. I asked Dalma what she thought about seeing her mom again. Although she answered she would like to see her, she looked absent (dissociated). I told her we were planning to arrange these meetings with her mom and siblings. I told her the meetings would happen in my office, with all her siblings and her being present. Her mother's therapist would be present, too, because she helped the mother in the same way I had worked with her and José. I reassured her that she was free to decide whether to stay or to leave, to talk or not, to ask as many questions as she wanted, and to say whatever she wanted to say. It was important for her to know that she had some control over this situation.

Dalma only wanted to know where her mom would go after this meeting. That was all.

But I had made a mistake—I had only addressed this issue with Dalma. Were the other parts of her aware of what was going to happen in the near future?

The next sessions were chaotic. The first session after this announcement, a regressed child entered my office. It was very confusing to understand what she was doing or pretending to do. With a freezing, crazy laugh, she took two dolls, had them play out having sex, then threw them, and asked me to go to the bathroom with her and stay there. She stated, "This is the first time I come here." She told me she was living in foster care because her dad bit her bottom, and that she did not see her mom because she was a bad girl.

I asked who was there in front of me. She did not answer my question. It was evident to me that I was interacting with another dissociated part of Dalma, somehow different than the others I had been working with, so I took the opportunity to ask if she was aware of the other parts. She said she was, but she especially knew Dalma and Debora. She claimed none of the girls let her sleep at night, so she was always awake at night. By then I knew the part that held all the negative, hostile aspects was Nada and, thus, had the strong suspicion that she was right there in front of me.

I had no information from the foster-care staff about any sleep disturbance in Dalma, no nightmares, sleepwalking, difficulty falling asleep, or difficulty

> waking up in the morning. Was she talking about a real experience while living at home with Mom and Dad? Was being awake a role that she engaged in while living with her family in order to protect herself, or to warn the system about the proximity of the abuse? I did not know, but those were hypotheses to be considered.

When I asked her why she was a "bad girl," she said, "Daddy told me not to tell Mommy about the things we knew." When we came back from the bathroom, the chaotic girl turned into a frightened child. She climbed up on my lap. And then suddenly she looked at a picture she, in the part I suspected was Nada, had been doing minutes ago and asked who drew that picture. Then a switch happened again: Dalma was back and had no memory of what had happened a few minutes before.

It seemed to me all the stabilization of the system we had achieved was now trembling. I was not convinced seeing the mother would be beneficial for these children. I did, however, continue with the family therapy as a chance to see whether anything in Dalma's external family system had changed enough to allow processing to continue.

> To be safe in the external world—which means to be cared for, protected from further abuses, believed and supported by the adults—is the first and most important consideration for the therapist who tries to help a child learn new ways to cope with stressful situations, in place of dissociation. When safety is not guaranteed, the therapist should not work to erode the only defense the child has to deal with these impossible situations.

The first meeting with the mom and children was complex. There was the mother, all four children, including Cecilia, the mother's therapist, and myself in a little room. The younger girls were looking for some kind of physical contact with the mother—not an affectionate contact such as one is used to seeing between a mother and a child, but some physical touching. The mom was unable to start an affectionate engagement. It was like she was expecting her children to initiate the interaction. The boy turned his back to the mom and started drawing. He was clearly saying he did not want to talk to her. Young Beatriz quickly left her mom sitting on the couch and went across the room and started solitary play with some toys. Cecilia was clearly angry and started questioning her mother. Throughout this, Dalma was sitting very close to her mom in silence and remained there for the entire meeting. Mom told her children that she had been doing therapy, that she was seeking help, that she had a new husband, and that she was going to have a new baby girl in the near future. Even though Mom's belly was evident, Dalma seemed not to see it or even to listen to her mom's news.

> These were logical reactions to a stressful situation (not seeing a mom for a long time, and then, suddenly one year later, seeing her and learning she was pregnant). This would be hard for any child in foster care due to abuse or neglect from parents. The children still needed an explanation about what had happened, why their mother could not see them for such a long time, and why now she could.

We decided that the first family sessions should address all the questions the children had about the things that had happened, and the mom should give them explanations without being judgmental. The mother needed to show understanding of the effect of the sexual abuse and her own neglectful reaction related to it. She should do this while respecting the children's needs and moving at their pace.

> Especially for young children, the issue of responsibility in sexual abuse situations is very important. Because of their developmental stage of thinking, they tend to assume that bad things have happened to them because they caused them, because they are bad, because they are not loved enough, but never because their parents had failed. This was evident from the dissociated parts of Dalma: Nada thought she was not with her mom because she was a bad girl. This could have been an introjection of some of the abuser statements to push her into silence. None of the kids were living with their mom, but it was not because they had done something wrong. It was their dad who was wrong, and it was their mom who had failed to protect them adequately from the abuse. But that was unlikely to be Dalma's perception and certainly not Nada's perception. It would be important for the adult persons who were responsible for this tragic situation to be held responsible for their actions or omission of actions.
>
> This was why the first meetings with the mom were used for letting the children express themselves, ask questions, and receive the information they needed for a better understanding of what had happened and, eventually, for their healing.

Why was she pregnant? Why did she have another husband? Did she know where the dad was? Why not? Why would she return home after the session and they could not go with her but had to return to foster care? Why was the judge mad at her? These were some of the first questions the children (primarily Cecilia and José) addressed to their mom. Dalma was always quiet, in silence, sitting beside her mother. At a certain point (three months had already passed since the beginning of the family therapy

sessions), the mom said she did not want to talk about the abuse yet. She did not feel prepared enough to face it. By this point in the family therapy, mom was no longer in individual therapy and her therapist stopped coming to the family sessions. The mother refused to see another therapist and said she came to the family sessions only because she was ordered to do so by the judge.

When Cecilia learned that her mother refused to talk about the abuse, she said she did not want to be part of the family therapy anymore. She yelled at her mother's face "We are here *because of the abuse* you don't want to talk about" and left the office. This was her last participation in the family therapy. Thus, I remained alone with the mother and the three younger children.

By Christmas, the new baby was born. In Argentina, Christmas season is in the middle of summer vacation. As the children were spending their vacation time at a beautiful big ranch outside the city, the disappearance of mom during these weeks was less evident for the children. None of the children asked for their mother during this period. The family therapy started again in March.

And now—the mom's big belly was a real baby. We arranged that she would bring the baby with her just once to introduce her to the children, but after that she was to arrange for someone to take care of the baby while she was at the family therapy. She agreed, but never did so. She claimed she did not have any help, and that her husband was reluctant to help her in this situation. Also, as she did not have a baby stroller, the mom came to each family therapy session holding the baby in her arms, and stayed this way the entire session. This completely limited the possibility of her being affectionate with her other children, taking care of them, and paying attention to them. It was important for Dalma and her siblings to know that, despite the new family member, their mom was there for them, had not abandoned them, cared about what they needed, and was able to respond to their demands with full attention. If she could first repair the bonding with her kids, then, in time, the new baby could become part of the family system.

But who wanted this to happen? Me.

When working with traumatized children, countertransference reactions may be triggered not only by the contents of the traumatic memories, but also by the parents' behaviors and attitudes. We look for a better parent, a parent who understands or who cares for this child. Or we may feel so touched by the parents' history that we do not notice the way in which the parent has been unprotective. Our own wishes (no matter how fair they are) may interfere with our being attuned to the child, or to the parent, if we do not notice these wishes and set them aside while working within the session.

As stated by Pearlman and Saakvitne (1995: 144), "It is valuable and self-protective to notice and experience our strong feelings about this work; these responses connect us with our humanity." But we need to work through our countertransference reactions to avoid developing internal obstacles within the therapeutic process.

Dalma and her siblings were brought by someone from the foster-care staff for the family therapy appointment. The mom would come alone from her home. After the family therapy session, I had individual sessions with José and Dalma. Mom would wait in the waiting room with the other children. After that, the children, the person from the foster-care staff, and the mom would go to the foster-care setting. Then mom, with the baby, would say goodbye and take the bus and go home. It was not the best framework, but it was what we had.

Dalma showed me how much dissociation she needed to deal with these family sessions. Within her individual therapy, she kept opening the Pandora's box of her dissociated parts. I was able to see Dalma acting very differently from her behavior in the family therapy sessions when she came to her own individual session. Her behavior during the family therapy did not change much. With the arrival of the new baby sister, she continued to sit beside her mom, lightly touching her sister's head, asking polite questions, "Is she good? Does she like to be bathed? What does she eat?" Her interaction with her mom was through her baby sister. Not a single question or comment about herself, nothing about school, nothing about her siblings, nothing about fighting with other girls in foster care, nothing about missing her mother or wanting to go back home. The entire conversation was around the baby. Dalma was adapting to her mommy's performance. It was the mom who did not, or could not, ask anything about Dalma's life. The only child to whom she asked personal questions was José, who continued his angry, hostile interaction with his mother. Beatriz would engage in play, sometimes teasing her brother, sometimes looking at her baby sister, pretty much lurking.

Dalma's overindulgent behavior towards her mother could be understood as a manifestation of what van der Hart et al. (2006) call "phobia of attachment loss." Attachment figures play a preponderant role in the development of dissociation: they are both the source of need fulfillment and the source of danger (or, in the case of Dalma's mother, the source of lack of protection from danger), and the cause of fear (and, in the case of Dalma's mother, being unprotective highly contributed to increased fear). The phobia of attachment originates in the hyperarousal elicited by facing the danger coming from the attachment figures. But danger is not part of

> the relationship all the time, and attachment needs still arise (especially in children); thus, the child needs/wants to attach and therefore is scared (becomes phobic) of not attaching—the phobia of attachment loss. According to van der Hart et al. (2006), these two phobias mutually activate in a vicious cycle depending on the slightest change in proximity or distance within any interpersonal relationship, and different parts of the personality might experience the different phobias. Dalma might have perceived how mom was looking after the baby, rather than focusing on her and her siblings, and she, being phobic of attachment loss, adapted to her mother's needs as a way to keep her mother wanting her. The counterpart of this phobia of attachment loss, phobia of attachment, was displayed by other parts holding memories of danger and lack of protection, as had happened during the sessions following the announcement of the future visits with the mom. Was the display in my office of this phobia of attachment towards the mom possible because she felt safe with me? This might be considered a possibility.

I felt myself mostly as an observer. I was looking at a family dynamic that seemed to have so little chance for movement. I certainly understood how hostile the mother felt about me. In the end, it was I who was responsible for informing the judge about her relationship with her children. It was I who had to confront the mother with the forensics examination diagnosis about the physical injuries her children received from the abuse. I was not a welcome person for her, and I was certain about that. I did not, however, see a defiant attitude in the mother when she was with her children. She responded, as it appeared she always had, with little contact, little interaction, no limits when they fought, few words when answering questions, and lots of candies. She would say goodbye asking the children, "What do you want me to bring you next time?"

During a few individual sessions following the family sessions, Dalma was involved in doing things her mom would like; for example, drawings and cards for mother and her new husband whom Dalma did not even know (initially, the mother's husband did not have permission to visit the children, and he had not shown any interest in doing so).

But after many family sessions, Dalma would enter the office for her individual session as an entirely different child—sometimes regressed, sometimes manic and hyperactive, sometimes varying from activity to quiet to confused to wild. Dalma was switching over and over again in only a few seconds. My work was primarily grounding, a lot of containment, a lot of stabilization and organization. Putting some order into my pencil box was something that calmed her down—classifying the pencils by size and color—and I was there accompanying her by counting one, two, three, orange, blue, green.

When working with traumatized dissociative children, a primary issue is safety. Safety refers not only to stopping the sexual abuse, as in this case, but also any other situation that might feel unsafe and therefore contribute to sustaining or perpetuating the use of the dissociative defense. In situations of sexual abuse, when the non-offending parent has been neglectful and the parent's attitude has contributed to the abuse, continued neglect for the child is a risk factor for safety. In this case, even though Dalma was living in a secure environment, her mother's presence would activate former memories. In addition, the mother appearing a year later with another child would be felt as abandonment. For an abused child, this situation would be the confirmation of many of the abuser's threats: "Nobody will believe you," "You will go to foster care," "You will lose all you have," "Mommy won't love you anymore."

It was clear to me that Dalma's way to deal with all the stuff triggered by her mom's presence was dissociation. Even if some authors would consider this counting activity as a self-hypnotic, and thus dissociative, activity (Terr, 1994, cited by Stien and Kendall, 2004), in the case of Dalma, this activity seemed more related to grounding and being present, and was the only activity that prevented her from switching over and over again. My voice and my presence there accompanied her movements of counting and classification, and were a connection to the here and now. Maybe at these moments, drawing or playing would have triggered more switching or more traumatic material that she was unable to handle at this particular moment.

Dalma was doing very poorly at school. Already in first grade, one day she had to draw herself and write her name, completing the sentence "I am . . ." She was not able to complete this assignment and not because of any inability to write or spell. I felt this block occurred because she did not know who she was—her dissociative disorder meant a lack of an integrated sense of self.

Dissociation can also affect the child's ability to learn and communicate, and that is why so many dissociative children fail at school. It is known that traumatized children are at risk for the development of language competency, and both social and academic skills (Yehuda, 2007). Dissociation can also disrupt the child's attention, thus disrupting the process of learning. A neutral stimulus can trigger the child, mobilizing the dissociative defense and making it difficult to focus attention on a particular task (Cole et al., 2005).

The impact of the baby was bigger than just her presence during family therapy sessions. By autumn, the mom started cancelling her appointments because it was too cloudy or too cold for the baby. Sometimes, mom would let us know just before the appointment and, sometimes, we just had to figure it out. She would later justify this lack of information by saying things like "I called but nobody answered, the line was bad." It was hard to make her understand how important the predictability of her behavior was for her children. The children needed to know that, even without living together, their mom was constant and predictable. The four children needed her as much as the baby did because she was their mother and they had been terribly hurt.

Constancy and predictability are two major conditions for a secure attachment. Child abuse within the family is contrary to these conditions; thus, we find all other types of attachment (avoidant, ambivalent, disorganized/disoriented) in abused children. For children who have been severely traumatized within their own families, working with attachment is paramount. The therapist needs to have a clear idea of how much it may be possible to rebuild this relationship, to change the insecure attachment pattern. If this is not possible, the therapist must be aware of the damage this relationship may create for the child and must assess how dangerous and risky it is for the child to keep this relationship.

Was the family therapy failing because I was providing both individual and family therapy? Was it because the mom did not have her own individual therapy? What would happen if I decided to suspend the family sessions and kept working with the children individually? Could things get worse? Eight months after family therapy started, with no consistency or cooperation from the mother, feeling myself completely lost and frustrated, I decided to suspend the family therapy and so informed the judge. At that point, he was allowing some visits during weekends. She would take her children for a snack in a nearby park without any supervision.

This decision by the judge added to my frustration—the legal and therapeutic systems were not working together. Were we becoming dissociative? There is a real danger when working with individuals with dissociation of the helping system becoming dissociative—another example of countertransference that needs to be attended to.

Third Phase of Treatment: Despair and Hope

Within a couple of weeks after suspending the family therapy, crazy, wild children came for their individual sessions. They were completely different from the kids I had seen during the last months; José was mad at his mom and calling her names. This behavior had not usually happened during his individual therapy sessions, only during the family therapy sessions. Dalma was acting again in a bizarre, sexualized manner, almost without control—moaning and rubbing against the couch—as she had during the first part of therapy. Was this confirmation that I had made a mistake?

José reported during the last visit that, when walking to the park, their mom asked the children if any of the things they had told about the father and his abuse of them was true. It was a single question, just one, but the damage was done. José laughed and told her it was true, Beatriz had run away to play, and Dalma had remained silent. The issue the mother had been systematically refusing to discuss in family therapy, she raised when she was alone with her children. There were no ears listening to her questioning, no professional there to explain to her the children's reactions, and no professional there to help the children contain this retraumatization.

I immediately called the mom to have an appointment and talk with her about what had happened. As I knew I was the last person she wanted to see, I started the interview acknowledging how difficult it would be for her to talk with me, considering that I was one of the people who suggested to the judge temporary separation from her kids. I explained to her why this had happened—I was not sure she knew the reason. The mother was on the defensive—she did not talk, did not even make a gesture. I told her I understood she had been warned by her attorney to be careful as to what she said, or to simply keep her mouth shut. There were, however, some things that were important for her children to be emotionally healthy: they needed to know how much their mom would actually see them, they needed to talk about what had happened, they needed to know why they were in foster care, and they needed to know what would happen if she eventually went to jail.

At this point, the mom acknowledged she was concerned about going to jail, although she considered this possibility as unfair because she had done nothing wrong. When I asked her what worried her most, she said "I don't know what would happen with the baby. Do you know if they will let her stay with me in jail?" I told her I did not know that and asked her if she had any worries related to her other children: "Oh yes, I won't be able to see them as often as I do now." Was she saying that she had already given up on being with her older children? That she was already used to *seeing* them instead of *living* with them? It was pretty difficult for me to understand how concerned this mom was about her older children and what this concern related to—it might have been her legal situation, or it might have been a genuine interest in her children.

So, I asked her what I finally needed to know: why, since she had the time during the family therapy sessions to ask her children about the abuse, did she choose a walk to the park with no one to help them or to help her with talking about this.

"I needed to know," she said, "I hadn't seen anything at home, so I needed them to tell me what happened so I could know."

I reminded her that the children had been examined by doctors when she was there and that the doctors had found evidence of their being hurt in a way that can happen only if children are sexually abused.

By making this statement, I was confronting her with the already existing information that confirmed the abuse: the medical findings were dramatic.

"Well, they must know why they say that. I haven't seen anything."

I asked if she remembered when Cecilia had told her about the abuse Cecilia had experienced. I said it must be hard for her to believe that could have happened and now to know that the same person had now done this to her younger kids, too.

> I was connecting the old facts with the current facts, trying to link her former reaction with the last one. It was important to know if she was able to change her view of the situation in order to be more supportive and protective of her kids. This was paramount information for deciding whether she would be able to protect her children in the aftermath of any other traumatic situation, and whether she would be able to prevent other situations similar to this from happening.

"I told you, I needed to know. I needed *them* to tell me what happened."

And what did you get from them after your question?

"Well, I thought they would react angrily or complaining that I didn't care about them. But no, José was laughing while insulting the dad, Beatriz ran away to play, and Dalma was silent. They were fine."

> Mom showed me that she was unable to connect with her kids' suffering. She took their reactions (what she saw as lack of reactions) as proof that they were fine. Dalma would need to remain quiet and in silence to fit her mother's expectations. Here, we see Dalma's dissociated part that was phobic to attachment loss. Quietness and silence kept her closer to her mom.

This mom needed more therapy and support than was available to reverse this situation She still refused to go to any therapist other than the one she had already seen. Time kept passing with the children still in foster care being visited from time to time by a mom who was unable to connect

with the things that happened to them. Besides that, mom was reconstructing her life and building a new family. She was aware she had no financial resources to sustain the whole family if the children were eventually returned to her. But, worst of all, was that she still held doubts about the abuse—this was the primary risk factor. With mom not believing the abuse had happened, the children would face an emotional victimization, as well as a potential new sexual victimization in the hands of any other person. Because mom was unaware of how to protect them or, even worse, that there was something to protect them from, she would not be able to prevent abuse from happening again.

In many countries, this is the work done by Child Protective Services. In less-developed countries, where lack of resources is part of daily life, many times we find ourselves as therapists doing double work—acting both as therapist and as a sort of child protective worker.

In these difficult cases, countertransference may take the therapist to the position of not trusting the parent or blaming the parent for the things the parent could not do. I was aware of my own strong countertransference reactions. I had to put them aside in order to focus on this mom's parental skills: that was what I had to assess and report to the court. Did she change her attitude toward the abuse? Did she believe her children? Was she able to protect her children from further victimization? These were some of the questions I had to answer through this conversation with her.

After a couple of these "crazy" sessions (such as the one that came after the walk in the park with the mom talking about the abuse), Dalma was able to settle down and act less disruptive and manic. She started worrying about being seen by her siblings as a crazy little girl because of the way she sometimes acted—switching from a cute, polite girl to a sexualized, acting-out one and then to a babyish one. I told her that in family therapy sessions she did act in a very different way than when entering the individual sessions and wondered if this was the change her siblings saw.

I asked her to draw how she felt this outside and inside.

One of the therapists' jobs with these clients is to make them aware of their behaviors or changes; helping them to know which part emerges when. This enhances internal connections.

This drawing technique I later called the Inside–Outside Technique (Baita, 2007) was created to help children talk about their traumatic experiences and the way they feel inside, in a more familiar, child-friendly manner. I explain to the child that there are things in her head that can be seen by everybody (this is the outside). Sometimes, if the child cries, other people

> might think he or she is sad, but they cannot know why the child is sad, unless the child is willing to talk about it. So, I go further and tell the child that there are some things that only he or she knows, such as the reason why the child is crying—these things are stored inside the child's head, and only the child can decide whether to talk about them or not. This statement gives children a sense of mastery over their mental contents, and this is very powerful for children who have been abused. So, the next step is to offer the child a piece of white paper with a circle drawn on each side of it and invite the child to draw his or her outside head and his or her inside head. I have seen children disclose the presence of dissociative parts through the use of this technique. I now regularly use it not only for assessment, but also during the entire course of treatment. The inside drawing might also be helpful as a map of the internal dissociative system, by showing not only the parts but also the kind of communication, or lack of communication, existing between them. This drawing can be done as many times as the therapist considers it helpful. Questions arising from the drawings can elicit more material.

Dalma made the drawings. The first drawing (Figure 2.5) represented how she saw herself on the outside, and the second drawing (Figure 2.6) represented how she felt *inside*.

On the outside drawing, she put pieces of black paper in the place of her eyes, and a piece of white paper for her mouth. On the inside drawing, her eyes were wide open, a little piece of pink paper was covering her mouth, and other small pieces of pink paper were all over the head. She referred to those pieces as "madness."

With these drawings, Dalma was able, for the first time, to explain her internal confused and separated experience as being part of herself, instead of belonging to different dissociated parts of herself. From now on, the experience of internal dividedness would be symbolized in different drawings and plays. For example, she drew one of *the inside kids* she used to defend herself against the attack from a bad grown-up who wanted to do bad things to her. In another picture, she had a dancer who had multiple heads inside her head.

During this third part of the treatment, the "multiple" drawings (drawings in which she used to make many human figures, or heads), evolved into doubles, in which she used to draw two people always very close—touching heads or arms, as is seen in Figure 2.7.

These drawings evolved in time to drawings in which Dalma drew a single person, sometimes containing things inside the head, sometimes containing other heads inside the head, and sometimes drawing nothing but telling me what she is thinking. This is represented by Figure 2.8, in which she draws a dancer saying, "Many heads inside my head. No, they

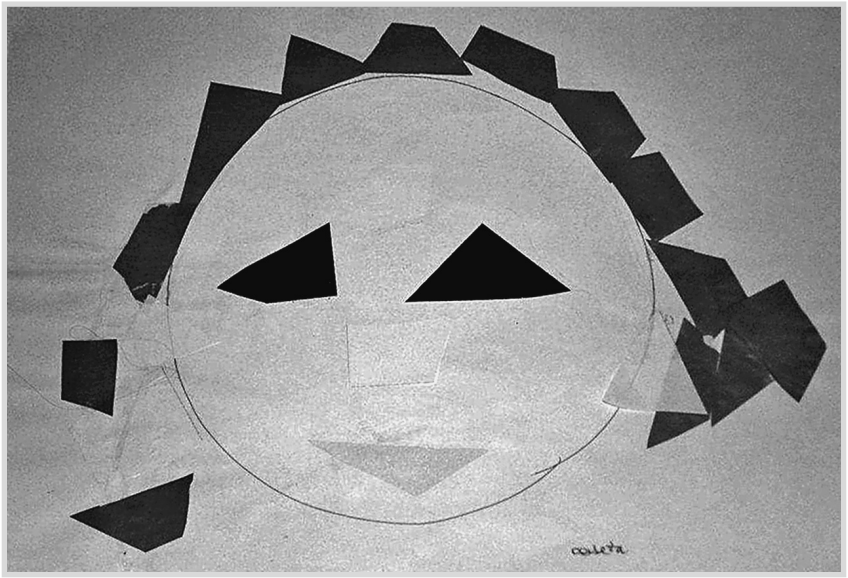


Figure 2.5 The outside of Dalma's head. (Used with permission.)

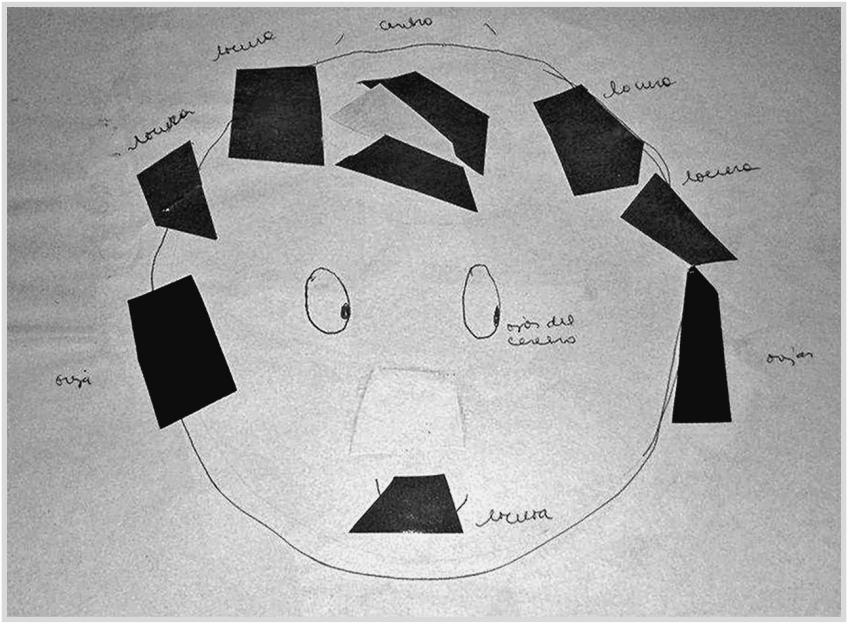


Figure 2.6 The inside of Dalma's head. (Used with permission.)

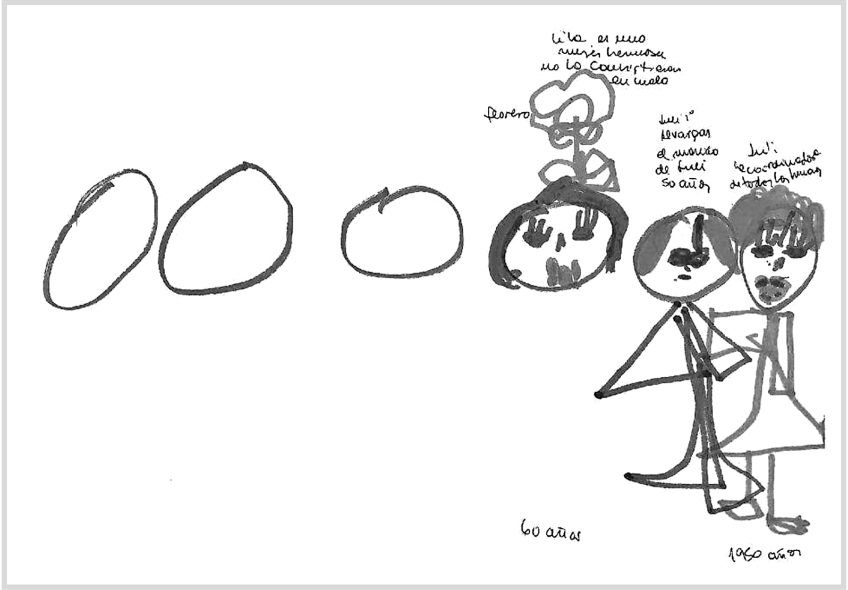


Figure 2.7 Two figures touching. (Used with permission.)

are bugs inside my head. No, I have so many things inside my head." The shapes above, Dalma explained, were the sun and clouds. These drawings were quite different from the first assessment drawings (see Figure 2.1) with things coming *out* of the head.

By the last months of treatment, Dalma was drawing a single person and then usually drawing somebody else overlapping with the first person without erasing the first figure. I decided to call these the "overlapping" series of drawings, as in Figure 2.9, in which Dalma drew a girl and then stuck a paper with another girl drawn on it on top of the first girl.

The unsupervised visits with the mother—which sometimes happened and sometimes did not—continued. Did anything change in her relationship with the mother? Nothing. But something had changed in the therapeutic space—for the first time, Dalma was able in the therapy session to express anger at her mom if her mom did not come to the visit with her and her siblings.

Dalma started engaging in more organized and structured play, and was able to continue playing as I made interventions—questions or comments on what she was doing—without any evident distress or anxiety, and without dissociating. She engaged again in the play about children (for which she used Playmobil® figures and a dollhouse) who have to be saved. This time in the play she indicated that the danger was coming from parental figures (both a mom and a dad) who acted confusing and tricky, "as if they were good parents." Dalma was responsible in the play for

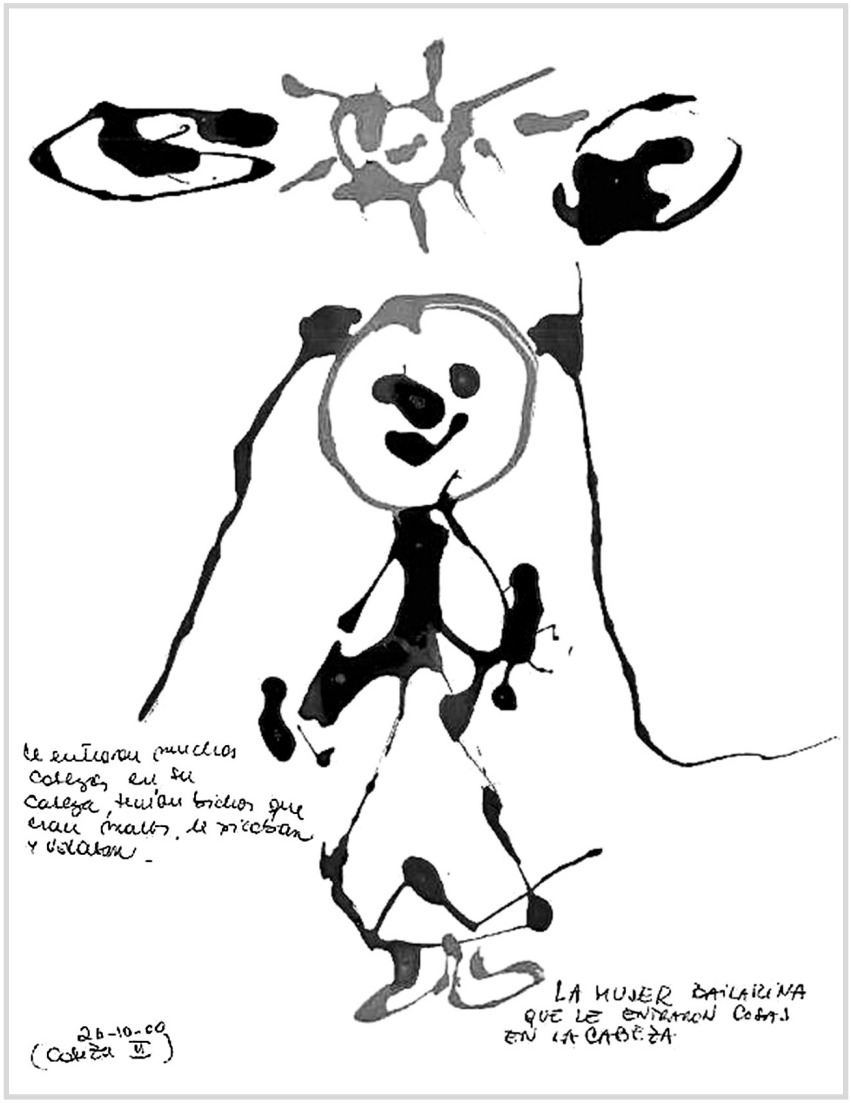


Figure 2.8 The dancer with heads inside her head. (Used with permission.)

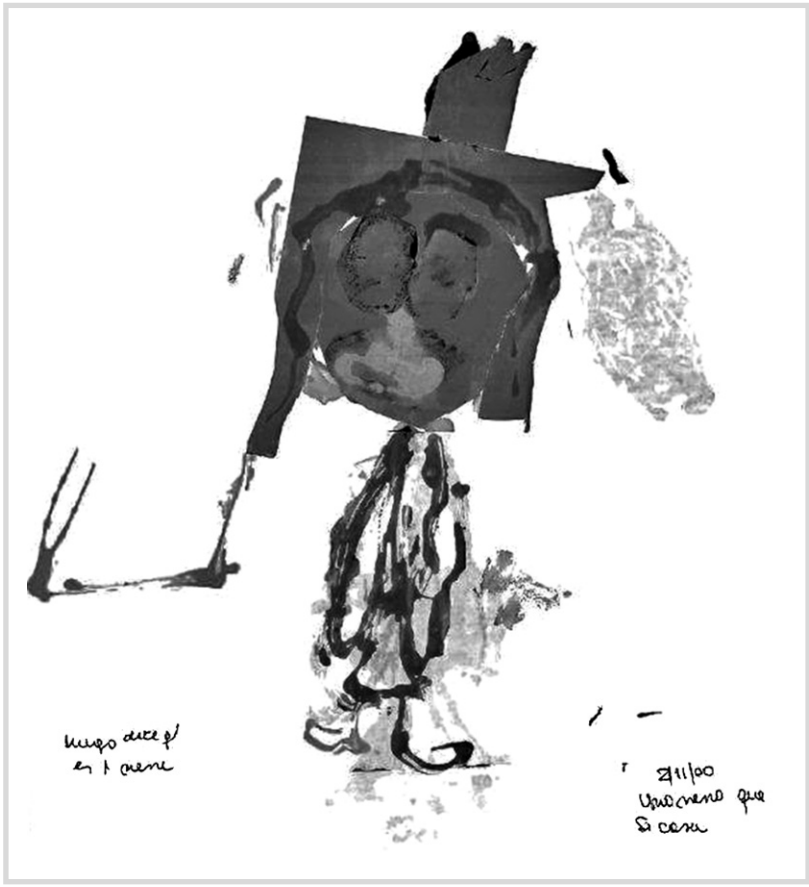


Figure 2.9 Girl overlapping other girl. (Used with permission.)

uncovering the parents' real intentions. She spent many sessions building a safe place, a house in which to hide what she started now calling *her* little kids, maybe her parts, to save them from the father who was looking for them. All of a sudden she asked me if I remembered her father's name, so I told her the name I knew. She said "No, he got another name, too, sometimes he made us call him with this other name. And he used to call me Debora, but I didn't like this name, I liked more Dalma. How did he call you when you didn't know us?"

> This innocent question showed me how much she had internalized her father's dynamics regarding the change of names. It was obvious for her that being someone else was somehow normal inside her home, and that it might also be a normal practice between adults.

I told Dalma that her father did not know me, but that, in case he would, my name was "Sandra," I replied. "I would not have allowed him to change it, because this is who I am—Sandra." Dalma stared at me and replied, "And I am Dalma." It was the first time this little girl referred to herself in the first person singular.

By the end of November of the third year, Dalma was doing very well at school. She no longer acted as a much younger child at school, in therapy, or at her foster home. The visits with her mom continued with the same rhythm to which she seemed to have adapted.

One day, she came into my office showing me her grades and her teacher's congratulations for all the efforts she had been making.

I reminded her of the drawing of the dancer who had many heads inside her head and wondered how much having all those "heads" inside had kept the dancer from doing all the things she wanted and liked to do. I said to Dalma that maybe she had a similar history to the dancer and now that her parts, her *kids*, were all safe inside a house where nobody could find them and where they were defended by her, she was able to do all this good work at school. Her own head was now still and clear and she could do her homework and pay attention.

> Maybe this explanation was too abstract for her young age and placed too much responsibility for her safety on her. Now that I have worked more with children with dissociation, I would probably note that the kids were parts of herself and that she, with the help of the foster home and all the adults who were taking good care of her, was now able to keep herself safe.

During our last session before the end of the year, Dalma created a play in which there were two sisters, named Sun and Moon, who were similar in almost everything—they could be "interchangeable." But sometimes they would argue and fight, and then an older sister would appear to fix things. This was Star, a very smart girl, who was always sure about who she was and what she wanted. When I asked Dalma who she would like to be in this play if she could choose, she replied to me, "Positive. I'm like Star!"

I smiled. Multiplicity seemed to be successfully resolving. This kind of play seemed more representative of interaction between ego states with flexible boundaries than interaction between dissociated parts with very rigid boundaries.

The End—Not as Good as I Would Like

The financial situation in Argentina made it impossible for the foster home to continue Dalma's treatment with me. Dalma and her siblings continued treatment with two staff psychologists at the foster place. They were

psychoanalytically trained, but without knowledge about dissociation and related disorders.

I lost contact with the children until three years later (six years had passed since the original report to the criminal court) when I was called to testify at the criminal court.

The children were still in foster care and I had the occasion to talk to the therapist who was treating Dalma. She told me Dalma was doing well at school. Nothing had changed in the visits with the mom except that she had another baby and was pregnant yet *again*. The father had been caught and that was why trial had been "accelerated." At the trial, the father was convicted and the mom was found not guilty. So, the moment for the family court to make decisions about the family had arrived.

Did the father's conviction change the mother's idea about the sexual abuse? Unfortunately, the answer was "no." The mother kept her doubts about the sexual abuse of the two little girls, while accepting that something might have happened to the boy. She was able to see his former encopresis as proof that something wrong had happened. Thus, nothing had changed in the thinking processes of this mom. But, by now, so many years had passed that the family court made the decision for the children to go back with their mom. No matter that she did not know how to be protective and prevent more abuses from happening in the future for her children; she would again be responsible for them, for their safety and their care.

Many questions continue to arise in my mind—how safe is Dalma, how safe are her siblings? What would happen with her dissociation in the face of new threats? What effect would it have on her dissociation to live with a mother who did not believe her? I repeat: safety is the paramount issue in the treatment of traumatized and dissociative children. It does not matter how good and skilled a therapist you might be, the child is surrounded by many systems that have responsibility for keeping her safe. If they do not do their job, the success of your therapy could be limited.

Dissociation is mostly a coping strategy. It helps the child avoid having to face on a daily basis terrible, overwhelming, and unbearable things that are happening within an interpersonal relationship, often within their caregiving system. Unless her life conditions change enough that she no longer needs to keep dissociating, the therapy process cannot dissolve this mechanism. By the end of my treatment with her, Dalma had gained a certain peace within her dissociative system, but, most likely, did not lose her capability to dissociate. Given her life circumstances, unless Dalma develops other very strong coping mechanisms, she may continue to need some dissociation.

Addenda: A Dissociative Family?

Dazzled by Dalma's severe dissociative disorder (as this was, as far as I know, the first reported case of childhood DID in Argentina), I now realize that I may have, while working in therapy with her siblings, missed their dissociation. It is obvious that living in such a dissociative and dysfunctional environment as this home could lead a child to use dissociation as a way to cope both with daily stressors and the more specific stressors such as sexual and physical abuse. So, why might José and Beatriz not also be dissociative, albeit not as severe as Dalma?

> The most recent studies on attachment have found that disorganized or disoriented attachment patterns are predictors of dissociative phenomena and disorders (Liotti, 1992; Lyons-Ruth, 2005; Lyons-Ruth et al., 2006; Schore, 2003). Frightening or frightened parental behavior (such as that of the father in this case) and parental withdrawal (such as that of the mother in this case) seem to elicit contradictory internal working models in the child. The child develops a disorganized or disoriented way of seeing himself or herself, and a disorganized or disoriented way of approaching the caregiver and world when in need of comfort and protection. This incompatible and insoluble conflict of seeking protection from the caregiver who is also a source of danger and harm lays at the center of attachment relationships in abusive caregiving systems.

Some of their drawings alert me to the possibility of some level of dissociation. And they remind me that I need to be alert to dissociative disorders that are not as extreme as DID. Dissociation is a part of the lives of many of our little clients who have to deal with overwhelming trauma with no physical escape.

Debora, the main alter of Dalma, spent a lot of time playing a silent scene in a bathroom where a man was about to make a sexual attack on a little girl who was lying on the floor while a little boy observed from a short distance. José had always denied seeing his father do this kind of thing. Yet, perhaps the act of spying forced him to be a silent witness. Lots of eyes had been drawn by José in his therapy, always wide open eyes.

Two years after the initial report, I started seeing Beatriz, aged 4, who showed me how memories of pain and suffering can appear several years after they have happened. One day she entered my office and asked me for a small piece of scotch tape. She used this tape literally to tape her mouth closed. After that, she took a piece of paper and red-colored glue that she emptied on the paper and mixed with some other colors. After she had filled the whole paper with the glue, she covered all her hands and arms, and then asked me to remove the scotch tape, and escort her to the

bathroom so she could wash herself. When we got back to the office, I asked her what she had done on this paper, and she stared at me. She replied with a simple, quiet answer: "It's blood, Sandra, don't you see it?"

I recall Beatriz playing alone and lurking during family therapy sessions, as if to isolate from her surroundings. At the same time, she had all these memories and pain inside. How, even though she was only 2 years old at the time she was abused and then removed from home, had she been able through all these years to keep all this pain aside? Dissociation seemed to be a good answer for this question.

The End

At the moment I am writing this chapter, ten years have passed since I first met Dalma and her siblings. I have presented the case of Dalma at many conferences and workshops, both in my country and outside of it. Some of my local psychoanalytically trained colleagues told me they would have considered Dalma as psychotic due to her bizarre and odd presentation, her switching between states, and her "delusional" claiming of being somebody else. And I was able to convince at least some of them that she was not psychotic but dissociative, a new term and a new paradigm for most of them.

I have been reading about dissociation since my first beginnings as a therapist. And I can say I still keep learning from my experience with Dalma and her siblings. The extent to which human beings can harm other human beings is beyond our understanding. Fortunately, the aftereffects of this harming on children keeps being better understood as clinicians work with the adults these children grow into.

So, here is the challenge for child therapists: we can help children to grow into more healthy adults.

And this is the special advice I want to share from my first experience—learn to see. Dissociation can often be there in front of you, and the children we are seeing need us to be the witness.

Editor's Comment

Sandra Baita provides us with the mixture of curiosity and amazement that is the experience of every therapist when meeting one's first client (child or adult) with DID. Dalma's amnesia, trance states, and switching between different demeanors were clearly apparent from both observation and history. For many children with dissociation, and particularly those with less extreme dissociation, the symptoms are not this clear. As Baita reflects at the end of her chapter, she would be more alert in the future to less obvious indicators (subtle changes in voice, mood, body position) such as may have been present in Dalma's siblings.

With this therapy, we become aware of the importance of working with nonverbal modalities (drawing, play) of therapy. Both because of Dalma's age at the time of the abuse (Perry, see Chapter 1) and because of the severe stress involved, much, if not all, of her memory initially would be held in implicit memory and in body memory, primarily right hemisphere functioning (Schore, see Chapter 1). As Dalma started drawing or re-enacting the abuse during the therapy, the memories became more accessible to her language and explicit memory functioning (Brewin, see Chapter 1).

Baita explains how, despite the recommended stages of therapy (safety and stability, trauma processing, integration), treatment is often shaped by the child's external world—the behavior of the family, social services, courts, and so forth. Within each session, we can, however, observe Baita's use of the stage model—safety, the "now" world, and the containment of strong feelings and sensations are emphasized before trauma events are addressed. We can observe the threatening self-states of Dalma calming as ideas for symbolic containment are provided. As this occurs, trauma work spontaneously emerges. Baita highlights for us the importance of sensing the child's pace.

Baita refers to "mapping" as a way to better understand Dalma and to keep clear in her own mind the roles of the different parts or self-states. Dalma's drawings assist with this mapping. Baita also used these drawings as she explained dissociation to Dalma, emphasizing for us how important psychoeducation about dissociation is for even a very young child.

Baita draws a parallel between the work of a therapist working with dissociation and a detective. It was important for her to be alert to possible other self-states. But with each "sister" or new situation described, Baita is careful to determine whether there was some basis for this in Dalma's external world. Baita attends carefully to her own reactions and noticed which belonged to the therapy process and which belonged to her, as the therapist.

Baita is very honest with regard to her countertransference experience with Dalma's mother. This highlights why having the same therapist for the child and the parent or the family is not recommended, although in some situations, such as this one, it is necessary. The difficulty of the work with the family—and, in particular, with Dalma's mother—is carefully and frustratingly explained. Particularly interesting to observe is how Dalma could retain the dissociation (needed because of her phobia of attachment loss) within the family sessions yet work toward integrating her abuse experiences during her individual therapy.

Through Baita's description of the changes in Dalma's pictures, play, and way of relating in the world, we are able to witness Dalma's movement toward integration. Yet, despite this healthy movement, Baita speculates that, as Dalma moves back into her mother's house, she is likely to need to use dissociation once again as a coping mechanism. While Baita helps

Dalma become more consciously aware of "her sisters," and through play, drawings, and conversation to process the feelings and experiences that had to be split off, at no point does Baita introduce the idea of total integration. Given the limited safety of Dalma's world at the end of therapy, emphasis on integration would not be therapeutic. We can hope, however, that her experience of being seen, validated, and kept safe within the foster home and within therapy will remain within her and will enable her, at some time in the future, to find safety and to experience a healthy level of integrated functioning.

Although Baita did not have the advantage, at the time of this case, of having read extensively in the area of dissociation, and did not have consultation to support her in her work, we can recognize connections with our present neurobiological understanding of trauma and dissociation, as well as ideas from each of the models discussed in Chapter 1. Baita's use of calming and naming of Dalma's safety within the foster family and within therapy would have helped to settle Dalma's HPA system and to lower the cortisol levels which, in turn, would have enabled better functioning in the hippocampus and the pre-frontal cortex, and would have helped to settle her autonomic nervous system. Refocusing Dalma on present safety was used by Baita to prevent retraumatization when Dalma started to reenact scenes of sexual abuse. By encouraging Dalma to draw herself and her sisters, Baita enabled Dalma to activate her right hemisphere in which early trauma and disorganized attachment is held (Chapman, 2014; Schore, 2012, 2013) and thus gave Dalma a way to express her early negative experiences. Each time Baita talked about the dissociation (early on, stating that all the parts shared a body and later on providing psychoeducation about dissociation), Dalma was able in her play or drawings to show more of her trauma experiences. This may reflect a decrease in the dissociative numbing which would have blocked memory retrieval. Most intriguing from a neurological perspective is the way Dalma presented as clearly dissociated during the family sessions and yet, during that same time, in individual sessions was able to draw and talk about her dissociated experiences, thus demonstrating, as Baita describes it, "connections between information networks" (page 62).

Without ever reading Putnam's writings (1989, 1997), Baita focuses in her work on understanding individual states, processing what each state holds, and building linkages between states, as suggested by Putnam. As Baita talks with Dalma about the feelings Dalma would have experienced both during and after the abuse, she is helping Dalma move through the affect avoidance as highlighted in the work by Silberg (2013). As we observe how Dalma differs in individual therapy, in the foster family, and when she is with her mother, we may be observing the tertiary dissociation highlighted by van der Hart et al. (2006) with different apparently normal parts (ANPs), each with their own more (with mother) or less (over time, in individual therapy) complex systems of emotional parts (EPs). Baita

recognizes Dalma's need to please her mother, referred to by van der Hart et al. (2006) as the EP experiencing a phobia of attachment loss.

Liotti's writings (1999) on attachment highlight for us Baita's frustrations and the difficulties Dalma faces as the courts place her back into her mother's care. From what we know about Dalma's mother, we can speculate that she came to her role as mother with an already established pattern of disorganized attachment. Dalma's mother had few resources and little support. It is unlikely that Dalma ever experienced an integrated sense of self but, rather, experienced from infancy the discrete behavioral states with limited neurological linkages such as those described by Putnam (1997).

Incorporation of Watkins and Watkins's (1993) ideas is less clear but can be seen, as Dalma's behavior in the foster home and school shows greater flexibility and ability to adapt to different situations.

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3 Jason (7 Years Old)—Expressing Past Neglect and Abuse

Two-Week Intensive Therapy for an Adopted Child with Dissociation

Renée Potgieter Marks

Jason entered the room holding onto the hand of his adoptive mother, shyly hiding behind her. His brown eyes finally met mine, innocently. Compliant, he sat down with his adoptive mother. After I introduced myself, he listened to what would happen next. As the adoptive mother left the room, big brown innocent eyes stared at me, and I wondered why I was asked to do an assessment. This child seemed so compliant, kind, such a lovely 7-year-old boy.

Thirty minutes later, I was struggling to get a positive response or even one simple request answered. Defiant, brown eyes barely looked at me as Jason reveled in planning a birthday party. There was no stopping the power of this child who now decided to take all the control. While he arranged biscuits on a plate with make-believe tea, he stuffed his mouth with a third biscuit and peeled the second banana.

During the assessment, it became evident that Jason had been exposed to complex trauma that had never been processed, and there were clear indications that he was also struggling with dissociation.

> I do all my assessments without prior information on the child. I find I am able to gather more information on the child by doing this type of uninformed or "blind" assessment. I start the assessment process with a semi-structured interview where the child usually tells me about school and friends, as well as the family with whom the child is living. During the assessment, I mainly use projective techniques such as projective pictures and story completions (Collins and Potgieter, 1996), projective play (Norton and Norton, 1997), and drawings (Oster and Crone, 2004).

Jason clearly was functioning within normal limits on a cognitive level. He introduced me to a nonexistent family consisting of four children whom he mainly described as "being horrible to me." He told me he had a "new mum" but was unable to remember her name. Jason's "favorite" phrase was, "I can't remember." He had no memory about any previous placements or the birth family. Looking at the projective picture of the family, Jason responded saying "grumpy" and moved away. When Jason identified "beer" while looking to a projective picture of the family where a person was sitting with a glass (possible indicator of exposure to alcohol abuse), he moved away from me and wanted to "go home." Jason identified the family members in the family projective pictures primarily as being "mad" and then physically started banging objects (displaced repressed anger). When looking at the self-projective pictures, Jason immediately regressed—picked up a baby bottle from the table and started to suck on it. He responded in an infantile voice. Jason often identified himself as "feeling bad." On the self-projective picture where an adult female was holding a child, Jason was the person "cuddling the child." It became evident that Jason could be either the parent of the child or be the regressed child who felt "bad."

> This inconsistency in the presentation of the self along with unprocessed trauma can be an indication of possible dissociation in the child. Children usually identify themselves with the child, rather than the caregiver of the child.

In the projective play, Jason insisted on having a "baby" whom he identified as himself in the house. The baby kept falling from the roof, calling "Help, Help!" but no one was able to find the baby or save the baby. Jason also added a number of children in the house. The moment that he placed the father figurine in the house, Jason impulsively moved away from the doll's house and refused to return to it. Jason now seemed to have lost all control and concentration. He started to function in a very fragmented manner, displaying regressive behavior one moment and extreme controlling behavior the next, while intermittently staring into space. He moved quickly from one toy to the next and was unable to enter into a coherent conversation with me. Jason settled when I asked him to draw a picture of a person. In this picture, all the body parts were disjointed.

> This picture reflected Jason's distorted sense of self. Based on these responses and others like them, it was clear that Jason was functioning in a fight/flight/freeze mode. The two hours of the assessment highlighted that Jason was living with the aftereffects of complex trauma. Jason's adoptive mother completed the Child Dissociative Checklist (CDC) (Putnam, 1997)

and Jason scored 20, which indicated that he was in the clinical range for pathological dissociation (the cut-off score being 12).

Jason had been referred due to his high level of aggressive and controlling behavior, as well as defiance. These behaviors had become too much for his adoptive mother to cope with. Jason would rage for hours, breaking objects and hurting his adoptive mother. He also displayed infantile and regressive behavior inappropriately. His adoptive mother was extremely concerned about these behaviors that had not decreased even though he was in therapy.

The second time we met was the first day of a two-week intensive therapy process.

As Jason was living a considerable distance from my office and, thus, I was unable to see him on a weekly basis, I decided to do a two-week intensive therapy with him (Levy and Orlans, 1998). I also felt this would be more beneficial for Jason, as I expected him to become quite reactive and volatile in his behavior as I started to work with the dissociation and to process the trauma. I based this on Jason's capacity to rage for hours at home when he became angry and his attacks on his adoptive mother. Also, for some children, when dissociation is first addressed, the extreme behaviors can intensify. This may be the internal self-states reacting to being recognized—a new and scary experience for them.

Because the intensive therapy included both Jason and his adoptive mother, I was assisted by a colleague. My colleague would be present during the therapy process when the mother and Jason were in the room. My colleague often did the Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2001) with Jason when I was explaining part of his story as we processed the trauma, or when we wanted to install positive experiences. Jason's preference was to be tapped on his shoulders. My colleague would do this as I drew pictures, shaped play dough, or created other physical metaphors for what had happened. Both of us were actively involved in the psychodramas and other activities used to help Jason express his anger appropriately.

The therapy was undertaken for a maximum of five hours per day, with breaks to make it comfortable for Jason. Due to the intensity of this therapeutic process, my colleague and I would have regular discussions during breaks about our observations and what we thought would be the best way to move forward. We also started each day by my having an individual session with the mother and my colleague having an individual session with Jason to evaluate where they were on an emotional and psychological level before planning the process of therapy for that day.

Day 1

My colleague and I initially planned with Jason and his adoptive mother what they would like to achieve over the next two weeks. Jason was shyly listening to what would happen during this intensive therapeutic process. We also explained the use of EMDR during the therapy and the different ways that this might be used. Jason was adamant that he did not have any problems at all or any "muddles" that needed therapy. We finally had to agree to disagree—everybody hoping that at some stage we would meet the part of Jason who had some insight into the extremely difficult and aggressive behavior he was displaying in his adoptive home. His adoptive mother was exhausted and felt like a total failure.

After Jason loudly protested that he did not want to listen to any of my "stories," he finally settled on the knee of his adoptive mother who was sitting on the carpet opposite me. I started to explain the process of coming into the care system (something Jason would have experienced years earlier) as Jason calmly and eagerly listened. I created a metaphor in which I used "Robbie," a little toy bunny rabbit that represented Jason. I started by explaining: "Little Robbie lived with his mum and dad who were fighting a lot" as I made attacking movements with the rabbits. "Oh, my goodness, just look at them, what do you see?" Jason quickly moved closer to see. "They are full of mud, look at his ear, it is ripped off . . . and they are hurting each other!" Together, we empathized with little Robbie who had had to live under these circumstances. I then proceeded. "Sadly, while the mum and dad were fighting, little Robbie also sometimes got hurt." Jason eagerly moved forward, tried to grab Robbie and wanted to "save" him from the birth parents. "Oh Jason," I said, "I see that you want to save Robbie!" I was trying to protect Robbie now from Jason's adamant efforts to save Robbie.

Jason eagerly explained, "I can look after Robbie, I have space in my room, I will look after him!" I tried to explain, "Shall we just quickly listen to the story and then we can save Robbie, will that be okay?" Jason agreed reluctantly but had trouble staying with the story as he continued to demand to care for Robbie. I finally got his attention when I used the "bear cards." This is a set of cards with bears, each depicting a different emotion. Jason decided that little Robbie felt frightened, sad, mad, bad, hungry, crying, and scared. It was evident that Jason was able to identify the real feelings of living in an unsafe environment. Jason's compulsive demanding to look after Robbie continued to the point where I was not able to continue the story.

"Mmmmm, I wonder who is the Jason who needs to save other people?" I asked.

> The aim of the bunny metaphor was to start the process of educating Jason on the journey through his traumatic early years. E stands for educate in

EDUCATE, the acronym used to describe Silberg's treatment plan for dissociative children (2013; see also Chapters 1 and 7, this volume). Educating both the child and the parent about how a child can be hurt by domestic violence and the types of feelings that may come up is an important step in helping them understand what has happened to them. I found Jason's behavior during this story out of the ordinary, as this is a story that I often use with children who have been adopted. Most children listen very carefully and attentively. Jason was different. There was a compulsive need in Jason to save Robbie and to "look after" him. In my experience, behaviors that become repetitive as well as disruptive usually indicate the child wants to tell me something very important. Children sometimes tell us the most important information through their behavior rather than through words. Behavior is the language a child uses when trying to explain internal distress to the world around him.

With the knowledge I had from the assessment, as well as from the mother's completion of the CDC regarding Jason's high levels of dissociation, I decided to move to the direct question about dissociation. In my experience, the child who is not dissociative will give a very different answer (e.g., "I just want to help Robbie") from the child who is dissociative. Jason's impulsive response indicated that this was a dissociative part.

"It is Lee," he answered without any hesitation. Jason eagerly explained that Lee was his friend who lives in his head and who always helps other people. The adoptive mother's eyes lit up, this was familiar to her. His mother had been seeing this behavior on a daily basis. Jason's high need to care for others was at a level that made his mother feel she was not in control. "I wonder if there are any other Jasons?" I asked. Jason nodded and said that there was "Alien" who was looking after Jason.

"Trauma shatters a child's perception of the world, similar to a rock breaking the window in their bedroom. The shattered glass represents the pieces of a child's experience. One piece may represent the images of Mom and Dad fighting. A second holds the sweet pungent smell of marijuana. A third piece represents the pressure in the child's chest as his or her heart beats fiercely, faster and faster until the child feels as though he or she will explode from within. A fourth holds shrill voices of anger. And, a fifth, the words of rage, the curses and obscenities hurled outward like lances as his or her parents struggled. Altogether, the trauma is unbearable. To survive, the child must break it apart into pieces, pieces that must not be allowed to connect because all together they would overwhelm the child. In this way trauma works like a shattered mirror (Gill, 1991, 1996) reflecting the child's broken

life and shattered identity" (Kagan, 2004, p. 34). "In short, when life itself is just too painful or too scary, dissociation comes to the rescue" (Shirar, 1996: 19).

Despite Jason's disruptive behavior, he had clearly identified with the story of Robbie and his journey from living in an abusive home with his birth family through five foster placements to the safety and security of the adoptive placement. Jason's responses at this point let me know that Jason had survived this journey of abuse, loss, and multiple rejections by adults by creating dissociative parts. One of the parts was Lee, who looked after other people, as that made Jason feel much more powerful. Another part, Alien, was looking after Jason and had kept him safe, even while he was living in adverse circumstances. Alien, of course, was also responsible for preventing Jason from attaching to his loving adoptive mother of four years—Alien was doing the caretaking that the mother wanted to do.

Children who have been adopted and suffered previous neglect and abuse—specifically, by the mother figure, or lack of protection, often develop a dissociative part that acts as an "internal mother-figure" caring for the child. This internal mother-figure dissociative part mostly acts as an enemy toward the adoptive mother, and resists her caretaking and parenting. This internal mother stops the child from getting his or her emotional needs met by the adoptive mother which, in turn, confirms to the child that he or she is neglected or unprotected yet again. This causes an enormous tension in the new mother–child relationship and can cause adoptive parents to feel utterly helpless and hopeless as their dreams of being a positive parent are shattered. The parent often ends up exhausted, suffering from secondary trauma with an intense sense that she or he is not able to be a good parent. In reality, no adoptive parent can win against the internal dissociative mother figure unless this part is specifically addressed in therapy.

We finally completed the story to the point where Robbie, the bunny, was safe, as he was now living with a special mummy who was able to keep him safe. Then I asked the difficult question: "Jason, do you know anybody with the same story as Robbie?"

"NO!" the impulsive answer came from Jason, emphatic and defiant. I tried again, "Jason, I think that there is somebody in this room with the same story as Robbie." Big brown eyes looked at me and then looked down and the answer came slowly as if it drained all his energy, "Me, I've got the same story." Jason was finally also able to say that he felt "sad" because of this difficult story of his life. Slowly, Jason started to understand that

he had "muddles" that were given to him by his birth family, and he agreed that he needed help with his muddles.

Jason quietly started to sob as he nestled into the arms of his adoptive mother. She was able to give him both empathy and emotional support.

Bowlby (1997) stated that the absence of the mother generates powerful anger and loss in the child. In my experience, children who have suffered the loss of a birth mother carry powerful anger internally that prevents them from evaluating the circumstances of their removal from the parent in a more objective way. Van der Kolk (1987), based on his research with children aged 6 to 11 years old with and without a history of abuse or neglect, stated: "Thus far, our strongest finding in these abused children has been the inflexibility of organised schematas and structures in all domains [of intelligence]. . . . Accommodation was not operating efficiently, apparently because autonomic nervous system arousal and steady state anxiety caused by conditioned fear and anticipatory frustration inhibited the ability to make guiding plans, to play with alternative approaches, or to anticipate probabilities at age appropriate levels" (p. 101). Abused children are often intellectually frozen at the age the trauma took place and, therefore, struggle to accept new information. It was evident Jason had experienced the "loss" of the caring and nurturing mother figure even before he was removed from his birth mother. The emotional pain of rejection, isolation, and nonexistence resulting from this loss is often covered by an intense anger. If the child can start to express his or her anger in a healthy way, the child has a better chance of finally connecting to, and thus resolving, this emotional pain.

The rest of the time on the first day was spent helping Jason to express his anger in an acceptable way without deliberately keeping any specific person or incident in mind. Fun reigned as he punched newspapers, punched the punch bag with the big gloves while making angry sounds, threw paper balls around, and used the inflatable hammer on the punch bag. This was done with intermittent squeals of laughter and a flood of swear words as Jason launched his body onto the punch bag and hit it fiercely.

During this session, Jason was exposed to so much emotionally difficult material as he started to realize the extent of his "muddles" and started to connect to his anger that I felt it was very important to give Jason some "grounding" in the form of love and nurturing from his adoptive mother.

The day ended with Jason in his mother's arms as she read a story about the big bundle of worries and also fed Jason pieces of caramel. I used caramel as it provides the combination of sweetness and milk that is present in breast milk.

This was Jason's first day of the intensive therapy. He was able to start making connections to his past and also to the anger, sadness, and fear that he had experienced. Jason expressed his anger as if a volcano had finally opened up. Jason was also able to disclose two of his dissociative parts. The main reason Jason was able to start disclosing his dissociative parts this early in therapy was that I asked a direct question. Children seldom disclose dissociation unless they are directly questioned. Also, Jason's previous therapy had addressed his attachment to his mother, thus helping him to achieve some sense of safety—an important prerequisite for work on dissociation.

In that a huge amount of emotion was touched on through this day, I felt Jason needed to have some grounding with the safety and reality of his adoptive mother's love. Jason especially needed to know at the end of this day that his adoptive mother still loved him despite his sad story and despite all his anger. Jason needed to connect to the safety and attunement from his adoptive mother.

Day 2

As we all sat down at the table, Jason sat close to his adoptive mother. I drew a brain on a piece of paper and started to explain how clever Jason's brain had been while he was living with his birth family. Jason initially started to listen but quickly hid his face in his adoptive mother's arm. Knowing that the story of his birth family was very painful, I told Jason that it was alright if he wanted to hide while listening to me telling his mother how clever Jason's brain was. Jason turned his back on me and buried his face in his mother's shoulder. I went on to explain that Jason had lived in very dangerous circumstances. It was so difficult for him that his brain made a very, very clever plan. The plan was that, since there was nobody to protect him, he would give one part of his brain to Alien so Alien could protect him and keep him safe like a special parent. Another part of his brain was given to Lee, who helped others. Jason now became interested and eagerly came over to color the part of his brain representing Alien. Jason chose his favorite color, blue (Figure 3.1).

I asked Jason to write the name of this part. He dramatically fell apart—his whole demeanor changed, his face drained of color, he stopped speaking, and he looked like he had given up hope. Jason again buried his head and started to make crying sounds. It sounded pitiful as if he was totally lost and confused.

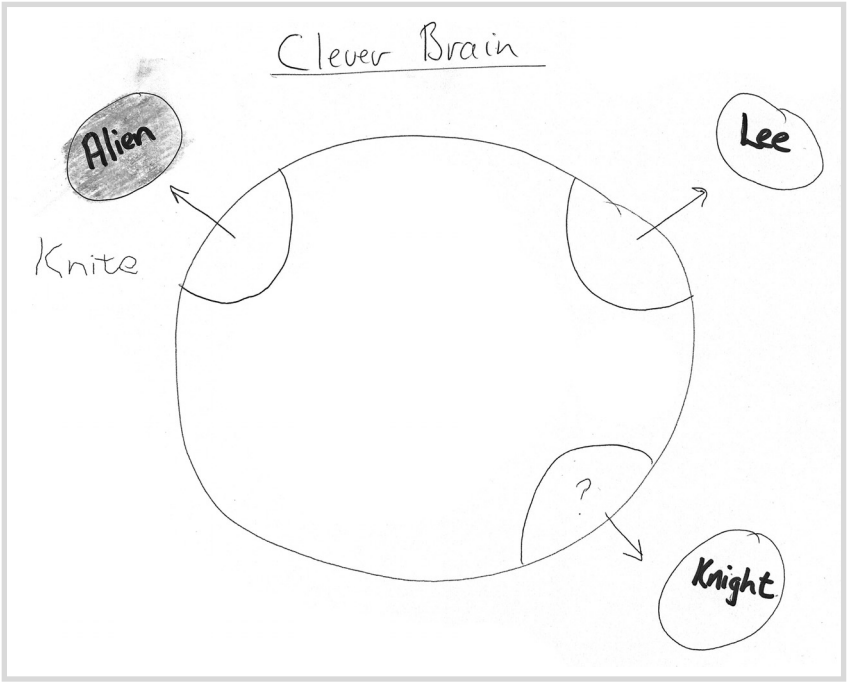


Figure 3.1 Drawing of Jason's brain. (Used with permission.)

The drawing and labeling of the brain was part of educating Jason on the dissociative process, thus including both the E and the D of Silberg's treatment acronym: EDUCATE (2013). This work also helped to address the U—Understanding what is hidden.

Jason appeared to be experiencing the pain and shame of disclosing the very system that had kept him alive for six years but that had been secret until now. "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 bad or wrong" (Whitfield, 1989: 44). Evans (1994) described shame as a creative way of adjusting to surviving a threatening environment. Now that Jason was connecting to the dissociation that had enabled him to survive his abuse, he was suddenly overwhelmed by a deep sense of shame, of feeling defective and bad about what had happened to him. Jason had no words for this and, thus, was left with having to externalize it through his body. Jason's body was telling me he was "falling apart." In my experience, this demeanor and strong sense in the room that the child does not want to

> exist are closely connected to shame. It seemed that Jason wanted to hide; he did not want to be seen or exist. The most practical way to work with this overwhelming feeling is to name the feeling in order to be able to work with it throughout the therapeutic process.

I felt a deep sense of emotional pain as I looked at Jason, who seemed to be reduced to a little bundle of nothingness. "Oh Jason, I see that you have a very *big* feeling right now. Do you know what the name of this big feeling is?" There was no response. I continued, "The name of this big feeling is shame. It makes you feel that you are all bad and horrible and that there is nothing good in you. Sometimes this feeling is so big, that it makes you want to just vanish. I think that is what you are feeling right now from hearing about all the difficult things that happened to the little Jason and all the plans he had to make to survive."

Silence reigned. "I wonder if I am right that this is the big feeling of shame? Can you please help me?" Jason slowly nodded his head. "I wonder how big this feeling is, as big as the paper, or the table, smaller or even bigger?"

"The room," the answer was barely audible.

"What a big feeling for such a little body! Where in your body do you feel that feeling of shame?" Jason pointed to his chest. My colleague placed the buzzers on Jason's shoulders and started EMDR.

"Wow, Mum, can you believe that Jason was able to make such good plans even when he felt all these big feelings of shame?" Mother responded with amazement and expressed how proud she was of Jason who could make such good plans. She added that she did not think he was bad at all. I expressed the amazing strength of Jason's brain to make this very special part, Alien, to help him. Jason became interested again and said it was the "Knite."

Confusion swept over me. "Can you please help me Jason, I do not understand." Jason wrote "Knite" close to the parent part of the brain that I had drawn (see Figure 3.1). I asked Jason to draw the Knight while I added the Knight as another part of his brain on the drawing. He started to draw the Knight, slowly and meticulously. When he finished he wrote the name, "Alien." I was even more confused (which usually means that I am working with dissociation) but finally managed to find out that the internal parent part who looked after Jason during the time of the abuse was Alien and the Knight was another part. This part seemed to be a more elusive part and one I was not allowed to know about—just not yet.

"Jason, can you please help me to understand Alien a bit better?" Jason nodded and I continued. "How old is Alien?" Jason showed one finger. "Oh, I see, he is only one. Is that years, or months, or weeks, or days?" "Days, just one day," Jason responded quietly. "What is his job?" Jason thought and said, "He is my friend, he looks after me. He started to look

after me when I was born." I expressed my admiration for how wonderful Alien was to look after Jason when he was so little and there was nobody to look after him. Jason started to moan softly. I asked Jason to tell Alien that I say "Thank you very much" for looking after Jason and explained that if Alien did not look after Jason he might not have been able to stay alive.

This was the start of analyzing the underlying motivation for why Jason was using dissociative strategies (D in the EDUCATE model, Silberg, 2013).

It is important to get to know the dissociative parts as much as possible. Initially, this may feel strange to therapists only starting to work in this field. Since we know that these parts have the potential to develop into full-blown personalities functioning outside the cognitive awareness of the child, increasing both our own understanding and the child's understanding of these parts is important. By getting to know these parts in terms of the age and the function, as well as why they developed, can be very helpful as a start to the therapeutic process. Acknowledging each part as a separate entity and being respectful of each by getting to know them facilitates a positive relationship between the therapist and each one of the parts. Through this process, the child can also get to know his parts and start to bring into conscious awareness the functions of these parts. Here, I was including the U (understanding what is hidden) and the C (claim the parts hidden) of Silberg's EDUCATE treatment plan (2013). Thus, one is working toward integration from the very beginning of therapy. Helping the child to know the function of the different parts also facilitates emotional regulation and, thus, improvements in behavior.

I asked the adoptive mother to write a letter to Alien to thank him for the wonderful job he did. She gently stroked Jason, shifted him on her knee and started to write:

"Dear Alien,

I just want to thank you so much for looking after little Jason when life was very difficult for him. I know that if you did not look after him, he would not have survived. I love him so very much and also love you for looking after Jason.

Lots of love Mummy"

I asked Jason to check with Alien whether he would listen to what Mummy wrote to him. Jason took a moment and then nodded. The mother gently moved Jason, who had stopped moaning, and read the letter to Alien. The big brown eyes started to smile again.

> It is extremely important to enable the parent of the child to have a good understanding of the dissociative parts and, above all, to express the parent's love to each one of the dissociative parts. If the parts sense that the parent does not love and accept them, the parts are highly likely to retaliate and become more defiant than before. This is especially true of the internal mother figure.

I asked Jason to draw the Knight. He drew a similar picture to Alien and wrote next to the picture, "Lee." Jason proudly said that Lee was his other friend in his head. Lee was 10 years old. Lee was looking after other people.

> Here, Jason started the process of claiming this part of the self that was hidden before (C in the EDUCATE model, Silberg, 2013).

Jason started to moan again while burying his face in his mother's shoulder. It seemed that connecting to the reason why he had to create his special dissociative friends to save him was very difficult for Jason.

"Oh Jason, I feel the big sadness that you have inside you when you start to remember about the bad things that happened to you. Do you know, I am so very sorry that bad things happened to you when you were a baby?" My colleague empathized as well and added that she wondered what Mummy would have done if she had been there.

Mother immediately responded. "I would have grabbed Jason and run far, far away from all the people who made him feel bad. I would have just given him lots and lots of love and cuddles and hugs and made sure that nobody ever hurt him again." Jason now started to smile. I summarized whom we had met today and what their jobs were. We all clapped and Jason smiled. He seemed amazed that we were accepting of his dissociative parts even though they caused him to be very dysfunctional in real life. I decided to explore the Knight later, as this seemed a very elusive part.

After the break, I decided to use a little frog in a transparent plastic dome as a metaphor. I asked Jason what he saw. He explained that it was a frog. Everybody agreed with Jason but I opposed him and said that I did not see the frog; I was only able to see the prince. Jason enjoyed opposing me loudly, but I kept on explaining that I was unable to see the frog, I was only able to see the prince. Finally, Jason and I agreed to fill the plastic dome with water. Slowly, the frog started to dissolve while I explained the process of melting muddles. Eventually, a prince emerged while I explained the process of getting to know the real Jason. Jason was jumping up and down with joy, and started to bargain to take the prince home. Proudly, Jason skipped with his mother to the bathroom to get rid of the green

water and to save the prince! Later, Jason explained the muddles, how they got melted, and how the prince emerged.

Traumatized children have great difficulty internalizing important information they are told. Trauma affects the way the child's brain functions, as well as a child's ability to concentrate, focus, and process information. Perry (2006: 29) said, "Simply stated, traumatic and neglectful experiences during childhood cause abnormal organization and functioning of important neural systems in the brain, compromising the functional capacities mediated by these systems." Using techniques where the child can experience the information through different sensory modalities—seeing, touching, moving, smelling, as well as hearing—enables the child to grasp information more effectively. A child who actively participates in activities is much more able to remember the metaphor or story. The story becomes the child's, as if the child created it.

This metaphor provided Jason and his mother with more education related to trauma and dissociation. The E of EDUCATE (Silberg, 2013) needs to be returned to time and time again throughout the therapy.

"I want to take the prince home," Jason exclaimed while I was still talking about muddles. "I want to look after the prince!"

"Well it all depends on how big you are," I answered. A bemused little face looked at me. "If you are bigger than the prince, you can look after the prince. If you are smaller than the prince you cannot look after the prince." Jason smiled—this was easy enough to understand. The principle was, the bigger you were, the better you were able to look after somebody.

My colleague and I started to measure. Jason was much bigger than the prince, so Jason could take the prince home and look after him. With a bit of a struggle, Alien agreed to be measured. I measured in years. Alien was 1 day old and was smaller than Jason and therefore was not able to look after Jason effectively. Jason was bemused. He was using somebody to look after him who was not able to do that at all. Lee was 10 years old and a bit bigger than Jason, so he could help look after Jason. But Lee's job was to look after others, which meant primarily the adoptive mother. In that the adoptive mother was much bigger than anybody in terms of years, Lee could not look after her. This clearly caused a big problem for Jason. After a short debate, the mother was measured again and Jason expressed his amazement that the mother was so big. Jason finally decided, "Only Mummy can look after me, she puts me to bed, gives me food and . . ." Jason continued to name the many things his mother did for him. I asked Jason to close his eyes and to tell Alien and Lee that they were all safe now while living with their adoptive mother. He was also to ask Alien and Lee whether they would allow Mummy to look after all of them. Jason

complied and after a couple of minutes said they were "okay" with this arrangement. There was a unanimous decision that the mother was the only person who could look after Lee, Alien, and Jason. Jason eagerly agreed and suddenly the adoptive mother not only had her child to care for but also had her child's dissociative parts to care for. She later jokingly announced, "I thought I adopted one child and now I realize that I am caring for a whole team!" Jason's mother was starting to realize that the dissociative parts had been actively stopping Jason from attaching to her.

> I have learned through my work with adopted children that, often, young dissociative parts do not know they have been adopted. The young dissociative parts seem to be "frozen" in time by the trauma and may be unaware of the existence of the adoptive parents. Because of the segmentation of the neuronal networks belonging to a younger part, that part does not have the knowledge of what happens later for the child—this information needs to be shared inside. Adopted children with dissociative parts often believe that they are still living with the birth family or that they are living with the foster caretakers. These dissociative parts can be extremely rejecting and abusive toward adoptive parents. Sadly, this problem cannot be addressed by focusing only on the attachment between the child and the child's adoptive parents. Unless the dissociative parts are also identified, accepted, loved, and integrated, the child often continues to experience attachment difficulties.

While I explained to Jason that Alien and Lee came to live with him to help him while he was living in danger with his birth parents, my colleague was doing EMDR by tapping him on his shoulders.

> EMDR can be an extremely valuable part of the psychotherapeutic process with children who experience complex trauma (Adler-Tapia and Settle, 2008). The process of EMDR is explained to the child during introductions. We tell the child and parent we will use it when we feel it will help the child to process distress, or to install positive experiences. While doing the intensive therapy, I mainly focus on the process and my colleague takes on the responsibility of doing the EMDR. During our therapy, EMDR is mainly done through tapping alternately on the right and the left shoulders, knees, hands, or legs of the child. Some children prefer to use the pulsars (buzzers), and they can be held in the hands, placed in the child's socks, in the child's pockets, or held onto the child's knees or shoulders. At the time of doing this therapy, I was modifying the existing protocol for children who suffered complex trauma and dissociation because of their level of physical reactivity,

their disconnection to their bodily feelings and emotions, and their level of distorted thinking. Thanks to advanced training I attended with Adler-Tapia and Settle, as well as their book (2008), I am at times able to follow the full protocol with validity of cognition (VoC) and subjective units of disturbance scale (SUDS) with children who have suffered complex trauma and dissociation. Most children who suffered complex trauma and suffer from the level of dissociation that Jason suffered are, however, unable to follow the full protocol, and continuous bilateral stimulation is used during the therapy process.

Shapiro (2001) describes emotional, behavioral, and mental health trauma symptoms as originating from maladaptive storage of previous life events. Trauma information is not stored in the same way as information that is fully processed. EMDR and bilateral stimulation facilitates information processing. It is specifically important for children in adoptive families to access the unprocessed trauma in order to make sense of their past, and to become aware of the extent to which old traumatic experiences are stopping them from fully experiencing and enjoying the love and nurturing of their adoptive parents.

Now that they were all safe, I was wondering whether Alien would like to have a new job, as he no longer needed his old job. Spontaneously, Jason closed his eyes and talked to his internal friend. Jason opened his eyes and started to write: "Alien's new job: To listen to Mummy." Everybody clapped; it seemed that Jason understood what needed to happen. Then Jason checked with Alien whether he would like a new name as well. Jason looked up and said, "I just want to be Jason." Alien agreed to be called Jason as well for now and to accept that he needed to help Jason listen to his mother rather than make Jason independent and self-sufficient. I suggested to the adoptive mother that she start to care more intensely for Jason and to keep on reminding him that she was the mother and able to effectively look after all the Jasons. She was to remind Jason that she was able to keep him safe.

I asked Jason to check with Lee, whose job had been to look after others, about what he would like his new job to be. Jason checked with Lee. "To help Alien to listen to Mummy." We decided that it would be good for these two team members to work together on this very important task.

Jason and his mother were in the privileged position that they were receiving attachment-oriented therapy from their regular therapist. This work had helped Jason to start to trust his mother, but not enough to give up his own need to control both her and the world around him. Attachment therapy on its own was not enough to stop the dissociative parts from working, and

therefore the attachment between parents and child remained problematic. Herman (1997: 155) stated, "Recovery unfolds in three stages. The central task of the first stage is the establishment of safety." In my experience, children who are suffering from complex trauma with dissociation are unable to be aware of the safety that now exists in their world and are also unable to access an internal safe place. For the adoptive child, it is essential to experience and recognize the safety in the relationship with the adoptive parent. Even though some adoptive children have some sense of this safety, they often still need to learn more about the ability of the parent to keep them safe and to internalize this concept fully.

Important in Herman's first stage of therapy and in helping the child to feel safe in his world is the A of EDUCATE: arousal modulation, affect regulation, attachment (Silberg, 2013).

Just before the story and cuddling time, I asked Jason to explain once more to Alien and Lee what they needed to do when they went home.

Day 3

Mother reported that Jason had reminded himself several times during the evening to listen to her. She also was able to be more active in her caring for him and, according to the mother, Jason started to appear calmer.

Within the session, however, Jason struggled to remember what had happened the previous day and needed a great deal of prompting to remember anything. Jason insisted that he could not remember. The day started with Jason asking my colleague to play with him with the doll's house. It became evident that Jason was reconstructing his birth family. Jason took the baby doll and gave it a carpet to lie on. He talked about helping the baby "not to get hurt." Jason placed the mother, father, and child figurines in the bed but left the baby alone lying on the floor. My colleague started to do EMDR/bilateral stimulation on Jason's shoulder while I was exploring the feelings of the baby. He said the baby was crying, but nobody was hearing the baby crying. At this stage, Jason moved away and refused the EMDR. My colleague said: "I wonder if you are getting big feelings?" He nodded.

Jason took the man figurine and explained that he was "falling out" and his "head is going to crack open." Jason explained that this man was "hurting the baby, kicking and smacking the baby." He moved away to his mother and refused to play with the doll's house again. Mother started to cuddle Jason and gently stroked his back. My colleague explained that sometimes when children think about the bad stuff, they think it will happen again. Jason nodded while she proceeded with the EMDR/bilateral stimulation.

During the play, Jason was reconstructing his birth family. This became a trauma trigger for the abuse he had suffered. His response was the same as it would have been if he had started to talk about the trauma. Play therapists need to be attuned to the intense discomfort a child's play may have on the child. Here, we were encountering the T (Triggers and Trauma) of Silberg's EDUCATE (2013).

My colleague continued to explain that it was very important for Jason to know that the bad stuff that happened to him had stopped and that he was now safe. "It is only the feelings about the bad stuff that are still there in Jason's head."

I responded, "I wonder if Jason wanted to run away when the bad stuff happened?" Jason laid quietly with his mother as my colleague and I discussed whether there was a possibility that Jason's body would have liked to run away but, as he was so small, he would not have been able to run away. Jason appeared to be in a freeze response.

Scaer (2005) said that most animals including humans have a series of instinctual behaviors that are automatically triggered by experiences that are a threat to their survival. He describes these responses as the "fight, flight and freeze" responses. The fight response often results in an impulsive attack on the parent or therapist. Children in the flight response display an impulsive need to flee from what they perceive during therapy as stimuli connected to the trauma. Children displaying the freeze response become immobile, frozen in appearance, and shut down. In practice, I have found it helpful to identify and name these responses in the children when they occur during trauma therapy.

Jason now started to make crying sounds, face buried in his mother's chest. "I am so sad for this little baby who was so very afraid and wanted to run away and could not run away as he was so small," I said. "I wonder if Jason would like to run away from the doll's house with all the hurts that he got inside?" Jason looked up with tears in his eyes. "I think that baby Jason was too small to run away when all the bad things happened to him and now he has big 'fly away' feelings inside his body."

The effect on the body of unresolved early trauma is described by Ogden et al. (2006: xxvii) as "an uncontrollable cascade of strong emotions and physical sensations, triggered by reminders of the trauma, replays endlessly in the body." Children are often not able to "talk" about their bodily

experiences. It is critically important for the therapist to note what the child's body is "telling" and to take this response into account during therapy. The therapist needs to respond with therapeutic techniques adapted to the language of the body for the child's body to release the trauma. This will include raising awareness of body sensations and then some form of body activity or movement. Ogden et al. (2006: 12) state, "In therapy we can utilize the outwardly directed physical manifestations to clarify, work with, and resolve trauma-related emotions."

Jason, who had stopped the crying sounds in the meantime, looked at me in anticipation. I got up and opened the two doors leading to the garden outside. I asked the mother to go to the top of the garden. I then looked at Jason who was now standing up. "Wow, just see how much this Jason baby has grown. He can walk and he can run! Would you like to stand next to the hurting house and then run out into the garden and see how fast you can run to your safe Mummy?" Jason smiled and nodded eagerly. The session ended with Jason running away from the "hurting house" in the therapy room through two doors to the top of the garden where his mother eagerly awaited him. Jason insisted in repeating this "running away" game again and again. Each time they connected, the mother hugged him lovingly, telling him how she would have loved to save him and how she will now keep him safe forever.

Peter Levine (1997) described the freeze discharge in animals that were traumatized. Levine proposes that this process needs to be completed in humans as well. I have found that children need to complete 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. These natural responses need to be completed for the child to be able to move on from the trauma. Having the child run away from the hurting house (which symbolizes the trauma) to his adoptive mother (who symbolizes safety) enabled Jason's body to do what he was not able to do at the moment that the trauma occurred.

After break, we started to look through Jason's life storybook made by his social worker. He was elated to look at the photos of himself as a baby. In one of the photos, Jason was lying as a little baby looking anxiously and his limbs were flexed and stiff. I wondered what this little baby was feeling. Jason found it too painful to identify the feelings of the baby. The needs of the baby were explained to Jason. Although Jason was initially eager to look at his life storybook, he started to cry when we talked about

Jason's life as a baby and how difficult his life had been, especially the information about the neglect and physical hurt. Jason laid in a fetal position. Each time his mother tried to touch him, Jason moved away and shook his body. Throughout this process, however, Jason did allow my colleague to hold the buzzers on his legs, which enabled Jason to at least process some of these painful memories.

At the end, Jason allowed his mother to make physical contact with him and finally allowed her to cuddle him while telling him how much she loved him. As Jason appeared in a regressed state, my colleague fixed a baby bottle of warm milk and gave it to the adoptive mother. The adoptive mother explained that she had been told that Jason as a baby was often hungry and not fed. People seldom held him when he was given his bottle. She offered him the bottle. Shyly, Jason took the bottle and sucked his milk eagerly while listening to his mother talk about how much she loved him. He was able to make occasional eye contact with her while the EMDR/bilateral stimulation continued at a slow rhythm, now installing a sense of safety and attunement.

Schore (2003: 13) refers to mother–child attunement when he states that "Interactive transactions that regulate positive affect—in addition to producing neurobiological, structural consequences—are also generating important events at the psychobiological level." An infant who has not experienced mother–child attunement struggles to regulate his or her own affect. Having missed out on close intimate connection between self and caregivers, this lack of connection often reappears for the child as problems in social relationships at school and in the peer group.

Children who suffered relational trauma early in life are not able to "learn" attachment from attaching to their therapist once a week. They need to experience attachment, emotional connection, and right brain to right brain communication (Schore, 2003; Silberg, 2013) with their caregivers on a daily basis. Experiencing this level of attunement with another human being over a long period of time not only changes behavior, but will also change the arousal system together with the psychobiology of the child.

Day 4

Mother and Jason told about the specific attachment activities my colleague and I had asked them to do. Mother had wrapped Jason in a blanket and rocked him. During this time, he was able to maintain better eye contact. Mother fed Jason some caramel while rocking and singing. Jason told us eagerly that the love was going into his "tummy." I told him the love has to go to his "love tummy" while food goes to the "food tummy." Jason

smiled, recalling a previous discussion about the fact that he sometimes confuses his "love tummy" and his "food tummy" and then he wants to eat all the time. Mother told us that after the cuddle time the previous evening, Jason hurt her by punching her. There was a bruise on the mother's arm. Jason was now moving away and hiding behind a pillow. I said, "I can see that Jason feels shame because of the hurting." No reply or movement. "I am certain that Jason did not want to hurt Mummy and now really feels so bad because Mummy was hurt. As I know that Jason does not want to hurt Mummy, I wonder who hurt her?" Jason was still hiding. I repeated the last question and heard a faint sound from behind the pillow. "Oh, I hear something, let me go a bit closer, who did the hurting?" I asked.

"Big John," came the answer, faintly. "So it was Big John doing the hurting?" I asked. Jason nodded.

> It is not uncommon for a child to disclose another dissociative part at a later stage after there has been some therapeutic input given to previous parts. This is called "layering" (van der Hart et al., 2006). In this case, Big John is possibly an introject of the abuser. Again, we are working with the U (Understanding what is hidden) and C (Claiming of the parts hidden) of EDUCATE (Silberg, 2013).

"Well of course if little babies are hurt by big people, they sometimes make a special part to be just as strong and angry as the people who hurt them. Then if the child lives with a safe Mummy, sometimes this angry part jumps out when he forgets about being safe." Jason was now listening intently. "Jason, can you please draw me a picture of 'Big John' so that I can understand him better?"

Jason came over and drew a picture of "Big John." While Jason was drawing, my colleague was tapping Jason's shoulders. Jason told me Big John came to live with him while he was a baby living with the birth family. Big John came to live with Jason because "they hurt" him. Jason refused to explain the hurting. He became increasingly agitated and started to move around on his chair. Jason abruptly disconnected—he stopped listening to us and moved toward the punch bag.

"I can see that you have big anger inside, Jason," I responded. "You are very clever to know that you can give the anger to the punch bag." Jason ignored me while punching the punch bag. When Jason stopped for a moment, my colleague suggested he draw on the punch bag the people who gave him the anger. On one side, he drew a male and wrote "Sam" who was the birth father. On the other side, Jason drew a female and wrote "Mary," the name of the birth mother.

"Let's pretend while you are punching them that you are also a news reporter. Can we place the buzzers in your pockets and the control system in your back pocket?" my colleague asked. "Then, while punching, you can also tell us what they did to you." Jason agreed and tolerated the EMDR well during this period.

Jason agreed and used the next forty minutes to punch, kick, hit, and shout at the birth parents. At times, he exploded with a memory. "You said I was stupid." "You said you hate me!" "You did not come when I cried." "You hit me when I was just small." A very tired Jason finally collapsed on the pile of pillows. His mother wiped the sweat from his brow and gently held his head while helping him drink cold fruit juice. It was time for a break.

After the break, I sat down with Jason and looked at the picture of Big John. "It seems to me that Big John sometimes gets a bit confused between Sam, Mary, and your safe mummy," I said. "Then Big John jumps out and hurts safe mummy." Jason nodded. "Do you know what, I think that the job of Big John was to hold all your hurting and angry feelings that Sam and Mary gave to you. That was a very clever plan for Big John to do that. What do you think?" Jason nodded again. "I wonder if we could help Big John and all the other Jasons to stop getting all mixed up between Sam, Mary, and safe Mummy?"

Jason's eyes lit up. "That is a good plan," he said and got up from his chair.

I moved a chair to the opposite side of the room against the wall. I asked Mother if she could sit in that chair. I called Jason to our side of the room and asked him to help me put a big piece of paper against the wall. He eagerly helped. At the top I wrote in red, "Sam and Mary."

"Now, Jason, I would like you to help me so we can make a list of all the things that Sam and Mary did to you while you lived with them. You can give me all the good and the bad things that you can remember."

Jason turned around and said, "I cannot remember." I reminded Jason gently that he showed us a couple of things in the doll's house that had happened to the baby that were not very nice. I also referred to the information he gave us while he was punching the punch bag. Jason insisted that he was not able to remember anything at all. My colleague, the adoptive mother, and I all worked together to prompt Jason to remember. We wondered what happened when Jason was hungry, what happened when he cried, and so forth. Bit by bit, Jason started to recall. Everything Jason remembered was jotted down on the piece of paper, written with the red pen. Finally, after what felt like ages, Jason suddenly started to remember many things that had happened. "She did not look at me, did not bath me, was swearing at me, said nasty things to me, was not kind to me." At the end, Jason took the pen and added more items on the list. There were now 19 items on the list, all negative.

We moved to the opposite wall where the adoptive mother was sitting. I put a big piece of paper next to her on the wall. I asked Jason. "Now, let's make a list what safe mummy is doing." You can give me all the good and the bad things that she does." Jason struggled initially, but decided to get some clues from the list of Sam and Mary. Changing the "did not" items to "did" Jason made a long list of 28 items. He added items beyond the fulfilling of basic needs such as, "takes me out special places, cuddles me, keeps me safe." I wrote it all down with the green pen.

> Attachment "reenactment, simply speaking, is defined as the recreation of old relationships with new people" (De Laney, 1997: 27). Foster and adoptive parents often struggle with inappropriate behavior from the child which neither the child nor the caregiver can explain. Objectively, the child's behavior toward the foster or adoptive parents is often a mirror image of the interpersonal relationships the child observed in his birth family. It is as if the child is in a default position and is left playing out the pathological behaviors to which the child was exposed as a young child. The hurt child is stuck at the age that the trauma took place, and that part of the child is unable to respond appropriately to the present parents.

I asked Jason to put the sunglasses on while he was looking at the list of Sam and Mary. He looked and said "It looks dark." I agreed that it would look dark as it has a long list of bad things. I then asked Jason to look at the list of the adoptive mother. Jason did and said that it was also dark. I said that was really strange as it was all good things. I explained to Jason that he will have sunglasses on when he looks back to what happened to him when he was small while living with Sam and Mary. If he uses the same glasses to look at his safe mother, it will also be dark. So, he needs to take the glasses off when he looks at the adoptive mother. Jason took the glasses off and looked at the adoptive mother and her list. "It is better now," he stated.

I was not certain Jason really understood the difficult concept of attachment reenactment or transference. But it did seem as if he had some understanding that the two lists were different. "Now, Jason, do you think you can get all the Jasons together—Alien, Lee, the Knight, Big John, and you? I have something very important to tell all of them." Jason rolled his eyes backwards, closed his eyes a couple of seconds, and said they were all present. I thanked all of them for attending and listening. "Do you know how traffic lights work?"

Jason nodded his head and started to explain. "The red is for stopping, the orange is for danger, and the green is for go."

"Very clever," I exclaimed. "Now, Jason, can you look at the list of Sam and Mary?" Jason did. "What is the color?" I asked. Jason replied,

"Red." "I wonder why?" Jason stared at the writing for a couple of seconds. He frowned slowly, stared again, and then his eyes lit up. "Because it stopped, it all stopped, it does not happen anymore." Jason turned to his adoptive mother and ran to her while he said, "This is green, and it is going on!" She cuddled him while laughing and discussing that the red means "stop" and the green means "going on."

> Jason's parts were all very young in that he had been traumatized at a preverbal age. It was, therefore, essential that information be explained to him in a concrete manner if all his parts were to understand. It was also important for Jason to understand the difficult concept of attachment reenactment and this exercise illustrated it to him in a very concrete and practical way.

Day 5

Jason was not able to recall any information about the previous day. He was also not able to recall any of the information that had been written on the lists about Sam and Mary and the adoptive mother. My colleague and I found that very unusual and wondered whether it was too difficult for Jason, at this point to proceed with the trauma information. We decided to stay with the stabilization phase of therapy and focus the day on attachment activities.

The day started with Jason wanting to punch the punch bag and to use the inflatable hammer and big set of boxing gloves to punch the punch bag. The rest of the day was spent with attachment activities between mother and child. The focus was placed on building trust through play activities and enabling Jason to become more aware of his body in a positive, nurturing, and loving way. Jason was very reluctant to trust his mother in most of the trust games. He also tried to take control by peeking through the blindfold or trying to dictate what the next game should be. It was hard work for the adoptive mother to keep on reminding Jason she was his safe mummy who would not let him get hurt. When Jason resisted one game, we moved on to another game that he was able to tolerate more easily.

> In this process, playful attachment activities were used to enable Jason to learn to modulate his emotions and behavior better in the context of relationship (A in the EDUCATE model, Silberg, 2013).
>
> Verrier (1993) states that there needs to be trust before love can be accepted by the child. During trust games, the child is placed in a physical position where he has to totally rely on the parent or adults around him to

keep him safe. I have created activities such as the child walking on stilts, jumping into the arms of the parent, balancing with the help of the parent on a gym ball, being swung in a blanket by the parent, and being blindfolded and led through a room or around obstacles. Keeping the child safe during these games is an absolute priority. While these physical activities are taking place, the parent consistently tells the child that the parent is safe, and will keep the child safe from any harm and hurt.

The latter part of the day was spent with activities helping Jason to experience his body in a positive way. Jason often spontaneously moved to the punch bag where he would spend some time punching and then joined in eagerly with the next activity.

In the process of normal parental interaction with a baby, the baby's body plays an important role. The parent touches, cares for, and nurtures the body of the child while playfully and lovingly naming the body parts and what they can do. This loving interaction provides a healthy concept of the body and initiates a desire in the child to explore his body and what his body can do and achieve. Neglected and abused children often miss this healthy developmental phase. Some examples of activities to promote a healthier concept of the child's body are drawing around the body of the child, making prints with aluminum foil of the child's knees, elbows, and face, and making handprints and footprints in plaster of Paris.

Jason generally enjoyed these activities but, at times, refused to allow the adoptive mother to participate. At one point, when Jason refused to do an activity with his mother, my colleague said, "I wonder who is not trusting Mummy?" Jason thought a couple of seconds and then said, "It is Alien." "Jason can you talk to Alien and tell him that this mummy is safe and that she will not hurt you?" Jason closed his eyes and then said he had told Alien. Alien apparently agreed to try his best to trust Mummy since in the next activity Jason was a bit more accepting of his mother's participation. Mother also reassured Alien that she was a safe mummy. She explained this by telling him that she will not hurt him and will not allow other people to hurt him.

Although Alien had tried to change his name and to give up taking care of Jason before, the problem of resisting mother had remained. Enough of the trauma had not been processed. With more work now done, Alien was able to successfully accept integration. The presence of the mother figure had clearly been a trigger for Jason and brought out Alien who caused problems

> in the mother–child relationship. It was important for the mother, Jason and Alien to know that not trusting the mother was one of the triggers leading to Alien's behavior becoming more apparent and causing problems. Sadly, often the very presence of the adoptive mother was a trigger for Alien to oppose the mother. It appears in hindsight that Alien might have been an internal mother figure that was present from the start of Jason's life in order to protect and care for him. An internal mother figure will inevitably resist attachment to the adoptive mother (T in the EDUCATE model, Silberg, 2013).

Poor Alien, he had had to work so hard for such a long time to look after Jason that now he found it difficult to allow his new mother to care for him. I was convinced that it would take some time for Alien to start to give up his job as the caregiver to Jason and to start to trust the adoptive mother. Alien needed constant reminding that he did not need to work so hard but that he could trust the adoptive mother to care for Jason.

I asked the mother to encourage this type of interaction between herself and Jason over the weekend. Jason was also asked to get all the Jasons to listen to his mother over the next couple of days and to see if they could all learn to trust her a bit more. We asked the mother to encourage all the parts of Jason to be present when repeating the activities we had been doing.

Day 6

On Monday, the mother reported that the weekend had been filled with nurturing games. At the same time, however, Jason had done a lot of shouting, saying how much he hated his mother. Jason was turning his head away and buried his head in his mother's shoulder, indicating that he was ashamed listening to this information.

Jason requested to look at his life storybook, which we did. Jason started to explain that he had an older brother whom he does not see presently. When I asked why he was not living with his birth family, Jason was unable to provide an explanation.

As Jason seemed to be confused at this stage about his family and why he was not living with his brother, I drew the outline of a house and asked Jason to help me to understand where in this house he had slept while living with his birth family. Jason eagerly participated and drew his bedroom, his cot and the Mickey Mouse blanket he had. While Jason was drawing, my colleague was doing EMDR by tapping his shoulders. I asked Jason where his cot was when he was a baby and he said "upstairs, no . . . in the living room. The dog slept in the kitchen. . . ." Jason suddenly looked up. "There was a dog in the house!" he said with a slight frown. "I also cried when I lived in that house."

"I wonder why little Jason cried?" I asked. Jason thought for a moment and then said "My mum fed me when I cried." He did not look particularly convinced about this information and said it with hesitation in his voice. This information was very different from the information Jason had talked about the previous week. At this point, Jason asked to go to the toilet. This appeared to me to be a flight response.

After Jason returned, I said, "It seems to me Jason has forgotten some of the things that happened when he was a baby. Can you remember about the difficult things that happened to baby Jason that we talked about last week?"

Jason shook his head—he had no recollection of the information related to neglect.

I then invited all the Jasons—Alien, Lee, the Knight, and Big John—to listen to the story I was going to tell them. Jason closed his eyes and checked whether they were all listening. I started to tell the story of Jason who was neglected, did not get food on a regular basis, lost weight, and was hurt and rejected. We looked at the same pictures in the life storybook. From time to time, I checked as to whether all the Jasons were still listening. My colleague was tapping Jason's shoulders, thus continuing the EMDR processing. Jason was alert, listening at times and at other times hiding his head in the shoulder of his mother who gently stroked him.

Suddenly, Jason started denying all the difficult times and the hurting that had happened in his birth house. "You really want this to have been a happy home, don't you," I said. Jason nodded. "This must be so very hard for you. Wanting this to have been a happy home where Sam and Mary would love you and look after you." Another eager nod followed. "Do you know that the social workers also wanted that to happen? They worked so very hard to help Sam and Mary to change and to look after you, but they just could not get it right. They were also sent to somebody to help them sort out their muddles, but they did not want to sort out their muddles. They liked their muddles a lot and did not want to change and to learn how to be a good mummy and daddy." Jason was now burying his head in his mother's shoulder making crying noises.

I drew a brain and divided it in two. "This is Jason's brain." Jason looked up. "Jason was so clever he made a special place on this side where he could hide all the difficult feelings, sadness and scary feelings. Here Jason is hiding all the bad things that happened to him like not getting enough food, having had dirty nappies."

"No kisses," Jason added. "No cuddles, being horrible," he continued, now being more realistic and eager to share the difficulties he had experienced. "They swear at me, they are nasty, they call me names, fighting, shouting at me 'Go to sleep.'" "That is exactly what the files said that happened," I explained.

Jason remembered information here that was accurate according to the background files. In my experience, I have found that during therapy and particularly during the use of EMDR, children often remember information about their early experiences amazingly accurately. The child usually has a normal part that appears like a child with no problems. This is referred to, within the structural dissociation theory, as the apparently normal part (ANP) of the personality. The parts that remember trauma information accurately and usually cause difficult behavior are called emotional parts (EPs). As van der Hart et al. (2006: 62) stated, "In secondary structural dissociation, various EPs are more tightly focused on specific stimuli or specific parts of a traumatic experience, and each EP is mediated by different defensive subsystems." Some of these EPs can remember information very accurately.

"Wow, just see how well you can remember now. I wonder if Jason sometimes does strange things at home?" The adoptive mother gave a catalog of difficult behavior—hitting, kicking, spitting, hiding feces, and eating and sleeping problems. Jason nodded uncomfortably in agreement, clearly aware of these incidents.

"Oh, now I can see what happens," I explained. "Jason is hiding all the big feelings and the difficult things that happened when he lived with Sam and Mary behind a beautiful picture that actually everything was nice and wonderful. Then all the big feelings and hurts under the nice story become all smelly, and then Jason starts to hit and kick and then he really starts to feel very bad about himself." Jason nodded eagerly. I continued, "When you do bad things, you feel bad. Poor Jason, he is working so very hard to try and tell us he is all fine and has no muddles." Jason smiled and nodded. "I wonder if Jason would like us to help him melt all these muddles so all the feelings can stop?" Jason nodded.

I followed a very direct and, to some extent, a confrontational approach here. Jason had already had a number of therapies where his life story had been completed and explained, but yet the negative behaviors had remained. It was evident that Jason, because of the dissociation of overwhelming past experiences, was unable to do the processing needed for his present behavior and internal reactivity to settle. Children who live in adoption with an idealized view of their birth family never really need to invest emotionally in their adoptive family. They remain attached to their idealized family. This idealized picture of the birth family is very often reinforced by the contact sessions after removal from the birth family. Sadly, no amount of love or devotion from the adoptive parent can change

the idealized view held by the child. Unless the dissociative system holding the negative information is involved in therapy and confronted, the child will remain emotionally connected to the birth family even while existing in the adoptive family. In this process, the adoptive family will carry, in the view of the child, all the blame for the child not being with his or her own family. In essence, in the mind of the child, the adoptive parent becomes the "abuser" and, therefore, not only is, but also should be, the recipient of the child's abuse.

After the break, Jason drew his birth mother on a big piece of paper. We placed it on the wall and I asked Jason, "What did the little baby Jason want to do while he lived with Mary?"

Jason thought and said, "Hit her and run away."

"Now, can we get all the Jasons here to work together?" Jason nodded. "Do you think that you can tell her what you wanted to do and why?"

Jason looked at the drawing of Mary and said, "You swore at me!" He picked up a ball and threw it at her. A tirade of accusations poured out while intermittently he threw balls at the drawing of Mary. "You hit me, you hated me, you did not feed me, you were horrible to me, you did not look at me, you did not want to talk to me, you did not hear me when I cried. . . ." Each ball that hit Mary was marked by my colleague, leaving the picture of Mary full of marks. Jason focused mainly on the face of Mary, especially the eyes and mouth area. Jason grabbed the bat and swung it at the picture again and again and again while releasing a flood of swear words.

With this activity, I was enabling Jason to release the "fight" response that he had clearly harbored toward the birth mother for so many years. Jason had been displaying in the adoptive home uncontrolled anger outbursts during which he would attack his adoptive mother. In therapy, he disclosed that the anger belonged to Big John, a dissociative state holding all the anger. By allowing Jason to release anger, he was not only able to acknowledge and own his anger—not have to dissociate it into Big John—but also to learn a socially acceptable way to disperse anger. Jason's body was able to "fight" the fight that he had not been able to fight while he lived with his birth family.

Finally, after being exhausted, Jason asked to be rocked in a blanket. His mother did this. The session ended with Jason in his mother's arms listening to her while she started to sing a special song she had made for Jason about how wonderful he was and how much she loved him. The safety of being with his mother and his enjoyment of this was installed with EMDR.

Day 7

Overnight Jason became very preoccupied with a teddy bear that had been given to him at some stage. He had not shown any interest in it for a long period of time.

Jason was totally unable to remember anything we had done or discussed the previous day. I found this extraordinary. Considerable time was devoted to reviewing the pictures and diagrams from the previous day until Jason was able to recall what was done. Even then, Jason was not able to connect to the angry feeling and was not able to identify the source of his anger. Jason was finally able to remember that Mary "pulled my hair, slapped my face, hit me in the chest and on my legs and hurt me." Then Jason said, "They can come and get me and I will have to go back." It became evident Jason still lived with a lot of fear that he might have to return to his birth family at some stage. I explained that he would never be going back. Jason did not seem convinced.

The whole process of being taken into care, the court process, as well as the fact that the birth family did not know where he lived was explained to Jason while he listened intently. I drew the court with the judge, social worker who represented Jason, and all the legal representatives. My colleague and I dramatized the court process where my colleague (enacting the social worker) was telling the judge all the information she had about the neglect and abuse of this little boy. I was adding questions from the legal representatives; for instance, whether the parents could not be given another chance. "Oh no," my colleague replied, "they had many chances and they have decided not to work on their muddles. I cannot allow this beautiful little Jason baby to stay there for another day!" I explained how the judge thought and thought and looked at all the papers and then made the best decision for little baby Jason.

Relieved, Jason hugged his mother and told her that he would not return to his birth family. "That means never, ever in my life?" Jason asked wide eyed, sighing. "I'll never go back; I'll never see her again!" Jason had a huge smile and his face beamed.

I reiterated, "You will never need to go back again because the big Judge in the court made the decision." Jason, smiling, jumped up and started to sing and dance through the room. We also made sure that all the parts of Jason knew this information. There was a real sense of relief in Jason.

Dissociative parts remain frozen in the overwhelming trauma, feelings, and experiences of the past. The dissociative parts act in the present as if they are still living in the earlier neglectful and abusive environment. Brewin (2005) describes how trauma becomes caught in right hemisphere functioning where there is no concept of past, present, or future, only a sense of things happening now. Verbalization of what has happened and is happening

encourages left-hemisphere functioning where past, present, and future are differentiated. Thus, it is important to enable the child and all the dissociative parts to understand fully what happened in the past, and to emphasize the difference between the past and the present. The child needs to recognize and experience the present as safe, different, and ongoing.

After break, I wondered what Jason would like to tell the birth mother whose drawing was still hanging on the wall. Jason smiled and went over to the drawing. "I'll never go back again! I hate you! You're nasty! You're horrible! You're stupid! I hate you! Nasty! Horrible! Nasty! Horrible!"

"You can also tell her what she did to you," I said.

"Kicked me, swore at me, pulled my hair, nasty, horrible, nasty!" Jason grabbed the balls and started to throw them at the picture. Jason asked for the bat. He hit the drawing of the birth mother, while grunting and snarling until he retired, exhausted, on the knee of his mother. "Can I rip her?" Jason asked.

"Sure, you can," I replied. Jason grabbed the life-size drawing and started to rip it to pieces. I wondered how this felt. Jason replied "Happy 'cos I won't see her again!" Jason pushed the pieces of paper in the bag. "That definitely got rid of her!" he said. "I'll never get to see her again!" He started to dance through the room singing. "I got rid of her, I got rid of her!"

"Is there anything else you want to do with the bag?" I asked.

"I think so . . . Maybe get the bag out and do something with the bag," Jason replied. "That's a great idea, we do not want her in this room," my colleague replied. Jason was now highly motivated to do something. "We'll definitely put her outside; I don't want her, she'll see she is in a bag." With this, Jason and my colleague went outside to put the bag in the bin.

This was clearly a major cathartic experience for Jason. He realized that he never had to return to his birth family. It seemed that, for the first time, his sense of safety was internalized. With this newfound sense of safety, Jason was able to finally release deep-seated anger and disgust about how he was treated by his birth mother. I had the sense that Jason had now started the journey toward connecting to the true story about his life. This would enable him to start connecting to his deep-seated emotions. Children who live in adoptive placements often feel they are living a lie. They are still deeply embroiled in the chaos of the abuse and neglect that they suffered while at the same time trying to live a "new life" with their "forever family." The expectations to make a new start for the child all too often omit the truth of what really happened in the child's life. Carizey (2004: 31) states the complexities of adoption can "result in a kind of splitting of the self into two other selves: the false self and the forbidden self. The false self is the part

that pretends to have been born into the adoptive family and rejects the importance of a birth heritage. The forbidden self is that part that still longs for the truth in its quest for an authentic consolidation of identity."

Because people try to avoid the topic of the "forbidden self," the child ends up holding the key to the prison of the child's traumatic experiences but having no one who can help him or her unlock the door, and face his or her painful past. Because professionals and adopters fear addressing the painful past of the child and write it off as "past abuse and neglect," an adoptive child is forced to use the bulk of his or her psychological energy to dissociate these experiences. This child, as a consequence, experiences attachment difficulties and extreme anger, becomes destructive and defiant, or withdraws and shuts down. The process of the intensive therapy described here gave Jason permission to find his key and revisit the prison holding the fear and hurt at the hand of his birth mother. As Jason found and faced the truth of his life, he was able to start emotional and psychological healing. It is only the truth that can really set us free.

Day 8

While I spent time with the mother, Jason made more spontaneous disclosures to my colleague about the fact that there was a man who hurt the baby on the head, arm, and bottom. When I entered the room, Jason immediately brought his teddy bear over and showed me the hurts on the head and the arm. We put some cream on the hurts. Jason was in the doctor role. As we were closely examining the "baby," Jason identified more hurts. "There at the neck, there is blood there!" He was not able to explain what caused it. "And the leg . . . and the hip." Jason was finding more hurts. Each one of the hurts was carefully healed with cream, plasters, and bandages while my colleague did EMDR by tapping on Jason's shoulders.

I felt Jason was stuck and asked if I could be the doctor. He eagerly agreed. He brought the baby to me with a sense of urgency. As I started to examine the baby, Jason explained that there was something wrong with the baby's mouth as well. "His brother pushed some medicine into his mouth." "Was there any other bad stuff that went into his mouth?" I asked. "Not really?" Jason reluctantly replied. I put the baby's mouth to my ear, pretending to listen to something that the baby was telling me. Jason hung his head, in a gesture of shame and quickly moved toward his mother. "I want my mummy," he said in a small voice. Mother embraced him, holding him close to her. I asked all the Jasons to work together. Jason nodded; he seemed to have all the Jasons there listening.

I summarized all the hurts of this baby and said the baby also has another hurt. I put the baby to my ear. "Oh no, he says that he also has bottom hurts!" I was going back to the disclosure Jason had made earlier to my

colleague. I was now addressing my colleague as I sensed that it would be too difficult for Jason to engage with me directly with this information. "This baby has bottom muddles as well! This baby is very ashamed because the people that give children bottom muddles tell them that the bottom muddles are their fault. This makes children feel big feelings of shame." Jason was hiding his head in his mother's shoulder while she gently stroked his back and rocked him. My colleague was doing EMDR.

I was now addressing the baby. "Little baby, you need to know that I know lots of children with bottom muddles and I can help you as well. I know it was not your fault that the people gave you bottom muddles, you were just a little baby who did not know anything about that! I wonder if Jason can help me to know what happened to the bottom of this little baby."

Jason asked, "Can we throw balls at him?" "Who?" I asked. "The boy," came the reply. "So you want to draw him and throw balls at him?" I asked. Jason nodded eagerly.

> Jason seemed to find it very difficult to connect to what appeared at this stage to be sexual abuse. Children are often paralyzed in shame when they connect to experiences of sexual abuse. This shame can act as a major inhibitor for connecting to their feelings of anger, fear, and sadness. After I addressed the issue of shame and guilt, and that any hurting was not the baby's fault, Jason appeared to connect to his anger. He expressed a clear need to externalize this anger. At this stage of the therapy, there was a sense that Jason understood that if he could express his anger, it would be easier for him to address the other feelings and experiences.

Jason moved to the table and drew a big person with a smile and wrote: Bad Boy Willy. Jason's choice of name further supported my suspicion that Jason had been abused by some older boys.

I asked, "I wonder which part of his body he used to hurt the baby?" Jason whispered, "His arm." "Can you please show me what part of his arm?" I asked. Jason pointed to the hand and added spontaneously, "Hit the baby's bottom with his willy." ("Willy" is a British slang term for penis.) Jason picked up the balls and started to throw balls at the boy. His gusto and powerful throws suggested an expression of pent-up anger. Finally exhausted, Jason tore the paper with the drawing of the boy off the wall and started to tear it into small pieces, while cutting some parts into smaller pieces. While Jason was doing this, my colleague continuing with EMDR tapping summarizing what this boy had done to Jason. Finally, Jason threw all the pieces of the drawing in the bin.

"Can you take him out in the big bag?" Jason requested. "I hate him; I hate him; he hurt my baby! I hate him! I really hate him, Mummy, he

hurt my baby! I am happy, 'cos I won't see him again, will I?" Mother replied, gently while stroking Jason's back, "Never ever again."

Jason moved back to his teddy, full of plasters and bandages. He picked him up. "Oh, baby, you are so poorly, aren't you?" With red cheeks and tired, Jason cuddled his teddy. Mother gently took Jason to the picnic basket and gave him a drink. He relaxed against his mother's body, clutching the teddy with his other hand.

Children with pathological dissociation are often unable to give a first-person account of sexual abuse. It is much safer for the child to give the account from a third-person perspective while projecting the experiences of abuse onto their younger child self (the internal hurt child), who in the case of Jason was represented by the teddy. This is also referred to as "depersonalization" where it is safer and easier for the child to project the abuse onto somebody or something else. The "baby" part that suffered the abuse becomes a dissociative part that holds the abuse and also acts as a victim part in the internal dissociative system. By having this part hold the abuse, the child can still function within the family system without disclosing the abuse.

Playing the doctor game provided Jason with a way to connect to the internal hurt child and enabled him to externalize the physical and emotional hurts the baby or younger part suffered. This provided a start to the processing of the traumatic experience of sexual abuse, as well as the start of the process to "own" the sexual abuse. Both are important steps toward healing and integration of this part.

After break, Jason wanted to play with Play-Doh®. I joined in and was wondering how Alien was doing with his new job of listening to mother. Mother explained that he was working very hard to listen to her. He was not always successful, but as soon as he was reminded, he was mostly able to listen to her. "I wonder whether Alien would like to have a new name now that he has a new job?" I asked. Jason nodded eagerly. "I wonder what you would like to call him." Jason thought and looked at his mother. "Let's call him 'Listen,'" he said.

"Can you check with Alien whether he will be okay with this?" I asked. Jason checked with Alien and nodded. We all welcomed "Listen" and congratulated him on his new job and his new name. I asked Jason to check how Lee felt about this arrangement. Jason explained that Lee was part of Alien, helping him to listen to Mummy, and he also accepted the name of "Listen."

"I wonder how large Big John and all his anger were when you came here the first day?" I asked Jason. "As large as this whole building," Jason replied. "Wow, as large as this whole building? Well, this is a massive

building; that is huge anger!" I said. "How large is his anger now?" Jason looked around. "It is only as large as the table now," he replied.

"I can see that Jason's brain was so clever that he gave all the anger to Big John. Big John has also done such a lot of hard work with all this anger. I think mother needs to know Big John still has some anger inside him and it may still come out a bit."

> Here, we are moving toward the last E (Ending) of EDUCATE (Silberg, 2013). It is important for the therapist knowing the internal world of the child to predict and prepare the adoptive parents for possible future problems that can be expected. This is specifically true of the intensive therapy process as the parent needs to understand that this is not the end of the process, rather, a very effective start to the process of change. The first E in Silberg's acronym for treatment, EDUCATE, becomes an important part of the last E (ending).

Jason became increasingly agitated and started to fiddle and moved away from the table. "I see that Big John still has some feelings and perhaps we need to show Jason how to help Big John to calm down. Do you think that Big John will be okay with that?" I said. Jason seemed to check inside himself. He nodded his head.

We moved to the carpet and did some jumping jacks in order to help Big John to feel more grounded and to calm down. I then asked Jason to sit with me on the carpet cross-legged and cross his arms across his chest and pat himself alternatively with his hands on his shoulder. "Can I do the rocking?" Jason asked, referring to being rocked in the blanket by mother and my colleague. Jason seemed to know exactly what he needed to calm down. We proceeded with the rocking while the mother was singing. As Jason calmed down and relaxed, I wondered whether Big John was tired of carrying all the anger and of hurting mother. Jason spontaneously checked with Big John.

"He said 'yes,'" Jason replied. I wondered what Big John would like to do instead of holding the anger. Jason looked at Mother, "I don't know." Mother said, "What about helping you calm down when you get angry." "Yes, that is a good idea!" Jason replied. I asked Jason to check with Big John. He checked inside him and said that Big John was fine with that. "Well, can you ask him what he would like his new name to be?" I asked. Jason checked with Big John. There was silence as the internal negotiations were taking place.

"He wants to be Mr. Calm." "Oh that is a very good name," Mother exclaimed. "Mr. Calm sounds strong enough to help you to be calm." Jason nodded. He was now fully relaxed as he was rocked to and fro in the blanket, holding the EMDR buzzers that I had set at the speed of a calm

heart rate in order to install the sense of calmness. Finally, the day ended with Jason moving with the buzzers to mother, who read him a book and fed him pieces of caramel.

> As Jason had never been able, because of very early trauma, to develop an integrated sense of self, the integration of the different self-states or parts is critically important. Each of these self-states was part of his developing self. Internally, they took on separate roles (holding specific feelings, actions, memories) in order for Jason to cope with his life in overwhelming circumstances. Pierre Janet explained dissociation as a division among "systems of ideas and functions that constitute the personality" (Janet, 1907: 332, as quoted in van der Hart et al., 2006: 28). "When Janet spoke of 'ideas' he meant not only thoughts, but psychobiological complexes (systems) that included thoughts, affects, sensations, behaviors, memories, what we refer to as mental actions. And [Janet] implied that those systems of ideas and functions have their own sense of self, even if it is an extremely underdeveloped one. For example, if affect or sensation are dissociated, they are still within the context of an 'I': 'I am terrified'; 'I feel pain in my stomach.' This sense of I may be quite discrepant with another sense of I that exists simultaneously: 'I am not terrified; I do not feel pain; I feel nothing.' Sense of self [or self state] may then be quite limited and restricted to awareness of only a small part of experience" (van der Hart et al., 2006, pp. 28–29).

Day 9

Mother reported during our individual session in the morning that, at times, Jason was viewing his teddy bear as a "baby" and at other times it was "just a bear." Mother had a good understanding that when the teddy bear was a "baby" Jason needed her to care for his inner child that was hurt and who was much younger than Jason was. Jason allowed her to do this and was also accepting mother's caring more readily.

My colleague spent time with Jason, who indicated by using an "emotions thermometer" that his anger, sadness, and scary feelings had shrunk significantly during the past couple of days. I told Jason how glad I was that the big feelings were getting smaller. Jason smiled as I was talking. "When you were a little baby, you were so very clever. When you were hurt and forgotten, your brain decided that this was so painful that he would give the bad stuff/the bad feelings to another part of your brain so Jason would not remember all that happened. I wonder what the name of that part is?" Jason responded immediately, "The Knight." "Ah, I remember now, we heard about the Knight before (see Figure 3.1 and text explanation). So what is the job of the Knight?"

"To forget all the bad stuff," Jason replied. "So, let me see if I can get this right. When things were really very bad for Jason, he decided to give all the bad things that happened to the Knight so he can hold the bad things. Then Jason could use the rest of his brain to do all the normal things he needed to do like eating, drinking, and so on?" "Yes," Jason nodded. "What a clever brain!" I exclaimed.

Mother also explained, "This may be why Jason can sometimes do maths and sometimes he cannot. Sometimes Jason can swim and sometimes he cannot. Can this also be the Knight?" Jason nodded his head in agreement. Finally, we knew where all the "I cannot remember" information came from. I explained that it is possible that the Knight may sometimes also interfere with some other important things that Jason needs to do and because he is not the part of the brain that learned how to do that activity, Jason then cannot do the activity.

This was a considerable learning curve for me as I was struggling more with Jason than with other children with whom I have worked to remember his background trauma information. In reflection, I realize that this may have been a countertransference process that often happens when working with dissociative children. "Countertransference responses are often considered a valuable tool for the therapist in understanding the client," stated Ogden et al. (2006: 180). Being involved in therapy with a child with pathological dissociation can hugely impact the therapist. The countertransference experience of the therapist in the therapy room becomes the mirror of the child's internal confusion: chaos, neglect, rejection, being forgotten. It becomes, for the therapist, a constant reminder of the unseen presence and pain within the child who lives with the impact of complex trauma. In my experience as clinical supervisor, I have, however, seen this countertransference experience lead not to further understanding of the child but to a sense of incompetence, confusion, and failure within the therapist. This may result in the therapist experiencing a sinking feeling when "that child" is due for therapy, in a premature termination of the therapy, or in avoidance of working with dissociative children.

There was a significant amount of amnesia during this intensive therapy process. At the time, I was often wondering whether this was resistance against the process and, in retrospect, I think I focused too much on that possibility. This was the first time I had encountered a part whose specific job was to take away all the painful information and deliberately cause all the information to be "forgotten," even after it was processed the previous day. There are often parts causing the child to forget a specific event or feeling, but this was unique in the sense that this part caused total amnesia of all the information. What made it even more confusing for

me was that this process repeated itself, despite our having completed significant trauma processing and having had a coherent narrative the previous day.

"I think the Knight has done a wonderful and amazing job! I think that if the Knight had not been able to take all the bad memories away from Jason, Jason might not have been able to live with them. I think we need to thank the Knight for all his hard work." Jason was looking at me with expectancy. "Mother, do you think you can write a letter to the Knight?" I asked. "Oh, yes," Mother replied, "I can do that." While mother was getting her pen, Jason asked if he could draw a special picture for the Knight. I agreed.

After drawing a picture for the Knight, Jason checked with his mother about how to spell "Knight" and wrote in big letters, "Dear Knight, fank you for helping me forget all the bad fings."

"Wow, Knight has worked so hard for so long. And he has worked very hard in this room! I wonder if the Knight is a bit tired of all the hard work he had to do?" I asked. Jason closed his eyes and checked with the Knight. "Yes, he is." "I wonder if he would like to have a rest?" I asked. Jason checked again with the Knight. He nodded. My colleague wondered out loud whether the Knight still needs to help Jason forget bad stuff that happened to him. Jason shook his head while starting to draw a new picture for the Knight. My colleague and I went into a discussion about how we admired the Knight for all the wonderful work he has done and how he had eased the life of the little baby Jason. We talked about how exhausted he should be after working exceptionally hard over the past two weeks to try to help Jason forget all the bad things while we were trying to help Jason remember the bad things.

Jason continued to draw, but he was obviously listening. We also wondered whether it was harder to push all the bad stuff away instead of remembering it. Jason completed his picture, which was exceptionally colorful in comparison with his earlier pictures. Jason wrote "To Knight." I commented on the beautiful picture and how colorful it was. "I am sure the Knight will really like his picture. Now I wonder if the Knight would like to have another job?" Jason wrote: "A new job for the Knight is to help Jason to remember all the things."

"That sounds like a very good job, Jason. How does he feel about this new job?" I asked. Jason smiled and said, "Very happy." "What is his new name?" I wondered. Jason thought a moment and said, "Remember." Mother read her letter of thanks to the Knight, and we all clapped as we congratulated Remember for his new job and noted that he will be very important in Jason's future. Knight, now Remember, would be able to help Jason remember all the things that he has to remember. Jason smiled broadly and seemed satisfied.

After the break, I wondered whether we had worked with all the people who hurt Jason. He immediately responded, "We didn't do the man." Jason eagerly moved to the paper and drew a life-size man. Following the same pattern as the previous day, Jason disclosed more abuse while my colleague did EMDR by tapping Jason's shoulders as I sat next to him.

Suddenly Jason remembered the dog that came while the man was abusing him. "The dog took me away to another house." I questioned Jason about a possible real dog being present, but Jason denied it. Jason was now busy throwing balls at the man, shouting, "I hate you, I hate you!" After Jason cut the "man" into little pieces and threw it in the bin, I inquired about the dog that helped Jason. Jason walked to the table and got the Play-Doh. He made the dog with Play-Doh. His name was "Dog." I explained to Jason, "When this man hurt you, it was so difficult for the little Jason baby, that your brain made this very special part, Dog, that could take you away to a place where you could be safe. Isn't that wonderful?" Jason nodded. "I wonder whether Dog would like a new job?"

> When Jason talked about the dog, I had to figure out whether this dog was a real dog who could have acted as a "comforter" for Jason during these adverse experiences, or whether this was an internal self-state or dissociative part that Jason created to escape the adverse experiences. In a child without dissociation, this dog would probably be viewed as a fantasy figure. Given that Jason experienced dissociation, writing the dog off as "just fantasy" could leave a significant dissociative part that would have the potential in the future of stepping in and causing Jason to be "absent" from difficult, but perhaps important, areas of his life as he became older. It is essential to address all dissociative parts if we are to enable the child to live life in the present, fully grounded, and with an integrated sense of self.

Jason shook his head. "No," he answered.

"I think that Dog still has a job to do to take Jason away sometimes because there may still be some muddles that we have not been able to melt yet," I replied. Jason did not reply and was busy making sure that Play-Doh "Dog" would stay in a special place until the next day. "That is fine, we will keep Dog safe as he still has some important work to do," I said. We all thanked Dog for his work and the session ended with mother rocking Jason while feeding him caramel. Jason was now looking in his mother's eyes for long periods of time, much more intently than earlier.

Day 10

Jason remembered for the first time during the two-week period the details of the activities of the previous day. I summarized the therapy that we had done so far and said, "I wonder if Jason still gets hurt now?" He looked at me and shook his head.

"Safe mummy keeps me safe now. Nobody can hurt me now." I brought Dog over. "Do you think you still need to have Dog to take you away?" Jason thought a moment and said, "No coz I'm safe now." We thanked Dog for helping Jason go away to another place when he was being abused by the man.

Jason decided Dog would like to change his name to "Play" as he could now help Jason to have fun and to play.

It is important for each new part also to get a new job. This provides respect for those parts of the self that dissociated when life was overwhelming and the "overwhelm" could not be absorbed within the functioning self. Receiving a new job and a new name also enables the young child to embrace and accommodate this part of the self, thus promoting integration and establishing an integrated sense of the self. Waters and Silberg (1996: 168) stated, "The authors believe that the fusion and eventual integration of all of the dissociative child's split-off parts is crucial to assisting the child to learn in school, to engage in appropriate behaviors, to develop his/her capabilities, and to form meaningful and lasting relationships. As long as fragmentation exists, the dissociative patient relies more on his or her dissociative defences, and this coping style becomes increasingly more ingrained."

Because the young child functions on a concrete level, it is important for therapy to provide concrete experiences such as new names and new jobs. In my experience, some children like to draw a new picture of the dissociative part illustrating this change, or to choose a different toy representing the changed function of the part.

I prefer to do integration with normal ego-state functioning in mind (Watkins and Watkins, 1993). The new job of a dissociative part is best placed if it fits into either the parent ego-state—Critical of Me or Nurturing Me, or the child ego-state—Adopted, Little Professor, Free Child (Freed and Freed, 1983). This approach enables the child and the parents to understand that normal ego-state functioning is acceptable as it is under the full control of the individual and promotes appropriate behavior, whereas dissociative parts function independent of the control of the child and lead to inappropriate behavior.

"There is one thing that keeps on bothering me. Little baby Jason was often hungry and he did not get the food he needed. I wonder if baby Jason has ever felt how it feels to be in the arms of a mummy who really loves him and who can give him a bottle of nice warm milk while the mummy is also giving him a big bag of love? I wonder if we can try it. Jason, do you want to pick a bottle? We have a Winnie Pooh bottle, Piglet . . ." Jason picked the Winnie Pooh bottle.

Can you check with "Listen" if he will allow Mummy to continue to look after baby Jason?" Jason closed his eyes and checked with "Listen" and nodded. "So, what shall we say?" I asked.

"Thank you."

I suggested that we needed to see if "Listen" would help Jason get all the care from Mummy that baby Jason had never received, and would help all the Jasons to feel Mummy's love.

While I filled the bottle with lukewarm milk, my colleague was helping mother to wrap Jason up in a soft blanket and helping mother and Jason find a comfortable spot. Jason eagerly started to suck the bottle as mother gave it to him. Jason curled up in a fetal position with his body snuggling into his mother's. Their eye contact was intense and prolonged as mother softly told Jason how much she loved him. Jason's body relaxed increasingly.

After a while, I explained that today was the end of the intensive therapy and that Jason had done such hard work during this time to melt his muddles. I explained that Jason's regular therapist would continue to see Jason and mother once a week to help them build their attachment. Jason relaxed in mother's arms, pretending to be asleep. It was evident that the journey of healing for the internal baby had just started.

Conclusion

Jason was seen on a weekly basis by his therapist who received a comprehensive report on the intensive therapy and consulted with me by email. During this time, emphasis was placed on helping Jason be more flexible and adaptive in new situations instead of using the old trauma based strategies (E—Ending in Silberg's EDUCATE model of treatment; 2013). The therapy focused mainly on the baby, his needs, and his attachment to mother. After about six months, I saw Jason once again to process another trauma memory he remembered from the time he lived with the birth family. I concluded my work with helping Jason understand that his birth parents had given him the gift of life and his beautiful body, face, hair, and eyes, but that they had too many muddles to give him the love and care he needed. I helped Jason forgive his birth parents for all the negative things that had happened. Jason is presently progressing very well. The baby part moved into spontaneous age progression with accompanied integration.

Working with all the parts of Jason, I identified his different dissociative parts, processed the trauma that was involved in causing each part to split off, and then moved to integration of those parts by enabling Jason to give each one a new name and a new job. With the baby part, I did not do that. In my experience, the baby part, which often presents itself at inappropriate times as "regression," is a critically important dissociative part. It is the internal neglected and abused baby who was unable to develop with the child's body and chronological age because the nurturing and love needed to grow and develop was not there. This internal baby part needs to experience the love and nurturing of the new parents in order to start to grow and develop. This can only happen over a period of time. This is done by encouraging cuddles and other nurturing experiences—nursery rhymes, songs, exploring infant toys and books, and being fed like a baby, or having a bottle or dummy—when the internal baby is also invited to be there. Because it is often difficult for parents to hold an older child in the typical baby position and hear this child making baby noises while suckling a bottle, parents need to understand the importance of providing the nurturing experiences the child missed in early infancy.

Cozolino (2006: 13) stated, "Our first months of life are dedicated to getting to know our mother: her smell, taste, feel and the look of her face. We gradually experience her ability to attune to us and soothe our distress as her presence becomes synonymous with safety." If a baby did not have these nurturing experiences and was flooded with domestic violence, abuse, and neglect, the baby will start to use dissociative parts to enable him or her to cope with overwhelming adverse experiences, while the baby part remains frozen deep inside. This baby part needs to be "thawed" through a slow process of loving nurturing. It is only through experiencing this love and nurturing consistently that the inner baby will spontaneously start to develop and grow until it matches the chronological age of the child. In this process, the parents are seen as the cotherapist who is actively promoting affective attunement to the child on a daily basis (Hughes, 1997).

Now, we have only one Jason. This is a fully functioning Jason who remembers how to swim and can do math "on a consistent basis." Remembers still happily working together with all the other Jasons, functioning in unison. There was a significant reduction of Jason's difficult behaviors, anger, and attacks on the mother. Jason is now able to reflect on his behavior, express his feelings, and look at alternative ways to manage a difficult situation.

> Jason was referred to me mainly due to his behavioral problems and an adoptive mother who was not able to "cope" with his behavior any longer. Although externally the parts appeared dysfunctional and were wrongly labeled as "emotional and behavioral" problems, internally these parts were adaptive. Any endeavor to get rid of the "behavioral problem" threatens the adaptive self-state and can cause it to temporarily go into hibernation, or to become more overt and aggressive. The therapist needs a good understanding of the function of each one of these parts or self-states, needs to befriend each one, and then enable each one to accept a new healthy function within the self. Once the self-state is willing and able to realize that the old pattern of functioning is no longer necessary, usually due to the establishment of external and internal safety, this part can become integrated, and the child moves to a more cohesive sense of self. Acknowledgement of dissociation, identification of the different parts, processing of the trauma, as well as integrating the dissociative parts, are specifically important in the therapy of a child who has dissociated.

Intensive therapy varies widely from child to child. The process, as well as the length and the outcome, depend not only on the trauma the individual child suffered, but also on the level of attachment established before the onset of the intensive therapy. The level of secondary trauma of the adoptive parent (the distress experienced from trying to parent a traumatized, dissociative child) can also influence the process during the intensive therapy. The parent's secondary trauma needs to be assessed prior to the onset of intensive therapy, as well as be monitored throughout the therapy.

Editor's Comment

In this chapter, we observe a therapist who has had many years of experience working with traumatized children who dissociate. The chapter is particularly valuable in that Marks highlights the significant and unique problems that arise for adoptive parents—the child not being aware of the new safety, the child not allowing the parent to care for him or her, and the child treating the adoptive parent as the abuser.

Marks is direct but non-suggestive in her questions to the child about dissociative parts. When working with the parts, Marks always works through the presenting child. Information is gathered as to why each part was created, and then, for most of the parts, Marks provides an activity Jason can do in the present that fulfills what he could not do during the trauma. Marks is continually attentive to Jason's somatic responses and is creative in providing activities that release pent-up emotions (punching, throwing balls) and activities that provide the nurturing Jason did not

receive as a baby (being fed caramels, being swung in a blanket). She is clearly attuned to Jason's concrete cognitive level with her use of concrete metaphors. Acknowledging all that the parts did to help Jason and thanking them is clearly described.

This creative work is interspersed with simple explanations of how Jason's brain helped him by separating off what was too frightening to hold.

Although Marks' description does not go into detail on her work with Jason's mother, one gets a clear sense that this is an important part of the work. Marks' reference to the parent's secondary trauma at the end of her chapter alerts therapists to the need throughout therapy with a dissociative child to attend also to the parent's experience (Wieland and Baita, in press), and to encourage the parent to persevere. As Marks tells us, dissociative children so often confuse the adoptive parents with the abusive parent and, as a result, attack the adoptive parent. Marks also refers to the therapist's countertransference experiences. These internal reactions may reflect the child's experience (Pearlman and Saakvitne, 1995; Wieland, 1997) and thereby help our understanding of the child, but, at other times, these internal reactions reflect our own personal experience and can block our understanding of what is happening for the child or for the parent. Awareness of countertransference and whether it is originating with the child or with us is essential for this work.

Marks' unique style of working for an intense two-week period is interesting. While most therapists in outpatient settings will not be able to do this, it is a therapeutic approach that could work quite well within an inpatient setting. The use of an "assistant" therapist, which allows for ongoing consultation and problem-solving is probably essential—so much needs to be sorted out in a very short time span. It is difficult to determine what role EMDR/bilateral stimulation played in the success of the therapy, but perhaps we do not need to factor out one type of intervention from another—what we do know is that Jason is now able to enjoy and react to life with an integrated self.

Reading through the story of Jason's therapy, we become aware of Marks' attention to neurological findings—the importance of building the parent's attunement to the child (Schore, 2003, 2012), the need for a release of the freeze response (Scaer, 2005), the importance of having activities related to the child's level of development at the time of the trauma (Perry, 2006), and the need for calming/emotional regulation. Marks' encouragement for soothing by mother at each session and between sessions follows Perry's emphasis (2006, 2009) on the need for repeated use of early somatosensory activities. Marks uses pictures, concrete metaphors, and movement to access trauma held in the right hemisphere (Chapman, 2014) and then enables—through her and, subsequently, Jason's verbalization (activation of left hemisphere processing) of the early trauma experiences—movement of situationally accessible memories (with no time context) to

verbally accessible memories (with contextual information of past, present, future) (Brewin, 2005). With this shift, Jason is able to start recognizing that the trauma is over. As Marks engages Jason's ability to reflect on what has happened, there is pre-frontal lobe activation which can be hypothesized as enabling a strengthening of the neuronal networks connecting to the amygdala and thus enabling calming but not shut-down (freeze reaction) of the fear/anger reaction (see Chapter 1). Although the exact neurological mechanism which is activated by the bilateral stimulation of EMDR is not clearly understood, studies have shown changes in brain functioning following EMDR treatment (Bergman, 2014; Gunter and Bodner, 2009; Levin et al., 1999).

Jason, similar to Dalma, provides an example of early dissociation. Putnam's discrete behavioral state model (1997), with the emphasis on early failure to develop moderate behavioral states and linkages between states, would apply here. Although Marks does not refer to Liotti's work (1999) on disorganized attachment, she is clearly working with the aftermath of disorganized attachment. Although Jason and his adoptive mother had already received therapy focusing on attachment, because of Jason's dissociation, only one part of Jason was able to experience secure attachment. Different parts of a child can experience different attachment patterns with the mother figure. As Marks notes, it is clear that attachment work undertaken without addressing the child's fragmented internal world will not resolve an attachment disorder. Likewise, therapeutic work without positive attachment to a parent-figure will not resolve a child's distress. Throughout the therapy, Marks encourages attachment activities between Jason and his mother. On Day 5, when Jason seems overwhelmed (his amnesia appears to have increased), they focus on attachment work.

Marks uses the structural model of dissociation (van der Hart et al., 2006) as a base to her understanding of the process whereby Jason is able to start remembering more and more of the abuse—EPs come into central awareness, the trauma held by a particular EP of the personality can be processed, reintegration of the EP into the ANP can then occur. Although Silberg's model of affect avoidance (2013) had not been articulated at the time of this therapy, the framework of dissociative parts being created to avoid painful affect at the time of the trauma is frequently used by Marks to explain the dynamics of dissociation to Jason and his mother. As Marks tells us the story of Jason's therapy, she highlights for us how the therapy has utilized the various parts of Silberg's treatment model—EDUCATE.

As the end of the two weeks is approached, we can notice greater flexibility in Jason's responses and his ability to remember the past while staying grounded in the present. Watkins and Watkins (1993) would refer to this as increased permeability between self-states. Marks refers to the importance of recognizing normal ego-state functioning as described by Watkins and Watkins as she encourages Jason's integration of his dissociative parts.

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4 Ryan (8 to 10 Years Old)—Connecting with the Body

Treatment of Somatoform Dissociation (Encopresis and Multiple Physical Complaints) in a Young Boy

Frances S. Waters

Ryan, a frail 3-year-old boy, traipsed into my office at the local mental health center with his parents and older brother, Victor, aged 8. I had been treating Victor for sexual abuse (infancy to 3 years old) by a babysitter. Victor was making good progress in his healing. Now, since the parents' attempt to train Ryan to use the potty chair for bowel movements had failed, they requested that I also work with him. So, Ryan became my client as well, and his symptom of encopresis was truly only the "tip of the iceberg."

Shortly after I began to see Ryan, he disclosed that he had also been sexually abused—not by the babysitter but by Victor. Ryan disclosed that Victor had touched his buttocks while in the bathtub and had inserted his finger and a pencil on several occasions into Ryan's anus while they watched television or played together.

Ryan and Victor had one other older sibling, Tommy, age 10, an active, outspoken child who denied he was sexually abused. Perhaps Tommy's strong personality was a protective barrier or made him less vulnerable to being victimized. The parents were advised to place strict boundaries on their sons' activities and to monitor them closely to prevent further sexually reactive behavior. The brothers were restricted from being in each other's bedroom except Victor and Tommy, who shared a room.

> Often, young sexually abused children will reenact their own traumatic experiences with other children or even adults (Freidrich et al., 1986), who hopefully would stop such behavior and seek help for the child. Sexualized behavior in young children is one of the most significant indicators of an occurrence of sexual abuse or of having witnessed such behavior (ibid).

Parental family history included alcoholism on both sides and some mental illness by a maternal aunt as a teen. Neither parent had a substance abuse problem. Their marriage appeared to be strong. Ryan's father was gainfully employed, and his mother, who had an associate's degree in early childhood development, was at this time a stay-at-home mom caring for their children. Both parents were supportive of their children and actively involved in their extracurricular activities.

After therapy began with Ryan, mother found toys with feces on them. Ryan admitted to sticking them and his finger in his anus. He appeared to be reenacting his own sexual abuse on himself. Mother also noted that Ryan was fearful of sleeping alone and experiencing nightmares. Ryan would crawl into his parents' bed or Victor's or Tommy's bed, despite their restrictions.

I began working with Ryan, with parental consultation, on stabilization and safety to help him with nighttime fears and success in using the toilet with a reward system in place. This had some initial success. Then, the therapeutic focus was on Ryan processing his traumatic memories and negative affect and thoughts with the use of drawings, clay, and anatomical dolls. He demonstrated with the anatomical dolls his brother's digital penetration of him and later made a clay figure of a horse (his brother's favorite animal) that symbolically represented his brother and pounded it as he expressed anger toward his brother. A family session occurred in which Victor apologized to Ryan for sexually abusing him and explained that he also had been sexually abused, which started his acting-out behavior. Safety precautions were also reinforced.

As a relevant note, during Victor's treatment, he had clear symptoms of dissociation marked particularly by a little boy dissociative state who separated at the time of his molestation and who played a role in abusing Ryan. Specialized treatment (Silberg, 1998) that incorporated this dissociative state into Victor's healing occurred, and this state was successfully integrated. Victor had no further impulses to engage in sexually reactive behavior, became more confident and outgoing, and showed improvement in school both academically and with peers.

Since Victor's treatment was successfully concluded, the parents decided to also terminate Ryan's therapy, even though he continued to have persistent encopresis and at times crawled into Victor's bed. I expressed reservations about termination, as it seemed that Ryan had not completely healed, and encouraged his parents to contact me if they wanted further services from me.

Five Years Later

Cathy Smith contacted me in my private practice requesting that I resume treating Ryan, who was almost 9 years old.

Contact with Mother

Cathy was seen initially to gather updated history. Remarkably, Ryan's previous symptoms had exacerbated during this five-year time span and new symptoms had developed. Ryan, despite apparently normal intelligence, had had to repeat first grade. During this time, he experienced some peer teasing because of his large ears and glasses. Most significantly, Ryan's encopresis had continued consistently over the years with no improvement despite the traditional medical treatment of mineral oil and a behavioral plan.

In retrospect, although Ryan's parents had not noted Ryan exhibiting any dissociative symptoms (such as amnesia for the traumatic events or current activities), it would have been wise for me to have assessed him more closely for possible dissociation, as you will note as you read on to his next stage of therapy. In fact, for some individuals there can be a familial component to dissociation (Mann and Sanders, 1994; Yeager and Lewis, 1996); Victor's and Ryan's dissociation might also point to a genetic component.

Perhaps Ryan crawling into bed with Victor may have been a dissociative state that was unaware of his molestation and, therefore, unafraid of Victor. Contradictory or confusing behavior may be a clue to underlying dissociative mechanisms operating—another reason for careful exploration of dissociation.

Ryan's sporadic symptom of encopresis appeared not only to be an indicator that his trauma was not completely resolved, but also perhaps a clue to a depersonalization disorder. Depersonalization, a disconnection from the body, would inhibit awareness of his bowel functions. A traumatic reminder, such as a need to excrete, could induce fear resulting in dissociative reaction. Bruce Perry's work (2001) has indicated that young traumatized children are prone to dissociate due to the physiological mechanism that involves a dissociative adaptive response when they are in a state of fear. Etiology of persistent, as well as emerging, symptoms can be rooted in the dissociative mechanism related to unprocessed trauma.

Since the time that I first saw Ryan, I have become more astute in my exploration of dissociation in young children (Waters, 2005a).

Mother noted extreme mood switches in Ryan from a happy, cheerful boy to a very angry and aggressive boy. He also demonstrated extreme fluctuations in school performance, receiving A's to F's from one day to the next on the same material. He had staring episodes, nightmares, and "night spells," as the mother referred to them, which occurred up to a couple of times a week and lasted up to an hour. These "night spells" were characterized by Ryan awakening between 2 am to 5 am with nausea, stomach ache, diarrhea, throwing up, severe headache, chills, and staring. The next day, Ryan would have no memory of these episodes. Mother recently had found evidence again of Ryan inserting toys in his rectum.

Ryan's mother also noted that "about three times a year, his countenance changed dramatically in voice and mannerism." His mother had ascribed this change to serious medical problems, as noted below. Remarkably, despite all of this, Ryan managed to play hockey fairly well over the years and was generally a pleasant child.

Cathy was an excellent reporter of Ryan's behavior and agreed to track his symptoms at home and at school with a chart.

> Parents carefully tracking their child's symptoms enables the clinician to analyze the frequency and intensity of mood and behavioral switches, possible triggering events, suspected amnesia, and degree of dissociation including possible presence of dissociative states.

Ryan's Medical History

After Ryan stopped seeing me, he developed allergies and chronic severe sinusitis. At age 8, Ryan was hospitalized for a week for sinus surgery and was administered two episodes of intravenous antibiotics, which were ineffective. Ryan continued to have sinus infections. A month later, he contracted meningitis and was again hospitalized. Ryan became a sickly child with recurring infections, low weight and height, and generally lacking spark. It was understandable that his moodiness could be attributed to his chronic illnesses.

> While his parents were supportive and present with Ryan during the hospitalizations, he may have felt vulnerable which could have triggered the earlier vulnerability from when he was sexually abused. This would likely contribute to further reliance on dissociation. His immune system appeared to be compromised, and I suspected a direct correlation to his unresolved early trauma—my theory yet to be tested.

At the time that Ryan resumed treatment with me, he had been evaluated and closely monitored by a pediatric neurologist for "night spells" that were suspected to be a seizure disorder. His electroencephalogram (EEG), however, was found to be normal. Because there were dissociative indicators and significant early trauma, I communicated with his neurologist about my impressions that the "night spells" could be pseudoseizures or symptoms of somatoform dissociation. I explained that somatoform dissociative symptoms are nonorganic (no medical cause) and occur when there is trauma that causes a severe threat to the body. It is an animal defensive response in which the body holds the unprocessed memories somatically, causing a loss of sensation or unexplained pain that is experienced by one dissociative part but not by another dissociative part. The symptoms can come and go depending on whether the part with a particular symptom is present (Nijenhuis, 2009). I suggested that, until I could more fully evaluate the extent of his dissociation, any medication for the "night spells" be deferred. Thankfully, the neurologist agreed.

In my work with Ryan, I followed the "Quadri-Therapeutic Model for Treatment of Dissociative Children" (Waters, 1996; in press), which combines four theories when working with traumatized children:

Dissociation Theory—Dissociation can be viewed as a defense mechanism to help a child avoid overwhelming feelings and a sense of annihilation when a traumatic event occurs. It is an automatic mechanism that preserves the self so that the child may be able to survive and function (Putnam, 1997). The child can "check out" and not feel or be aware on a conscious level across all sensory domains when a traumatic event is occurring. In the extreme form of dissociation, a child can form dissociative states—separate states of awareness—in which the child separates from himself or herself and develops states or "parts" that contain unwanted, traumatic material, such as thoughts, feelings, and behavior. It is important to note that it is still one child but "separate states of consciousness." In extreme form, dissociative identity disorder (DID), these states with separate levels of consciousness have impermeable barriers between the states with only one or some states holding some aspect of the trauma. The impermeable barriers prevent the flow of information among the states and with the external world, causing partial or complete amnesia for behavior and for events in the world. These states can contain different feelings, thoughts, behaviors, and bodily sensations. When they take control over the child's body, they can exhibit frequent, extreme, and confusing shifts in mood, behavior, thought, and bodily senses.

Attachment Theory—Drawing on the early works of Bowlby (1973, 1980, 1999), attachment theory is the foundational theory, in that progress is often

contingent on the child having healthy, supportive attachment. This theory analyzes the attachment style the child has with his or her parents, the relational impact of this attachment on the child's identity and behavior, and any obstacles to attachment. Liotti (1999) and Ogawa et al. (1997) examined disorganized attachment style and the predisposition to the development of dissociation. Taking attachment theory into consideration, it is important to work with the parents to develop acceptance of all the dissociated states of their child. This acceptance is the groundwork for promoting in the child trust, security, and the development of an integrated identity.

Developmental Theory—This encompasses the knowledge of child developmental stages (Erikson, 1950) and highlights how the extreme switching of behavior or moods from regressed to pseudomature can be possible signs of dissociative states.

Family Systems Theory—Family systems theory (Satir, 1983) views the family as an emotional unit and examines the interplay among family members. This theory looks at the family interactions and the impact of these interactions on the child's symptoms. Family communication, rules, and values can either decrease or increase a traumatized child's need to rely on dissociation when feeling unsafe. Whenever possible with young children, I include healthy, supportive parents in the therapy sessions. Their presence can enhance the resolution of trauma and the integration of the child. The reader will note the benefits in this case, in particular. In this case, I generally saw the parent(s) at the beginning of each session to review the behavioral chart and the frequency of their child's symptoms, and to lay out a collaborative plan with the parent(s) for the session's focus.

Throughout the course of treatment, I integrate this theoretical model in my interventions.

Ryan presented a convoluted picture, given his severe and chronic medical condition. His moodiness and changing behaviors certainly could have been ascribed to the medical condition. Because his medical symptoms were "center stage" when he came to treatment this time, it would have been easy to overlook the impact the early sexual trauma had on the development and continuation of his pseudoseizures, chronic infections, and changing moods. Taking that approach would most likely have led to another treatment failure, which I was not willing to repeat.

Treatment failures with traumatized dissociative children often occur when the focus is on the current, most pronounced symptom(s) and not on the etiology of the symptoms. When the treatment is focused on symptom reduction only, the symptom may momentarily cease but will often recur

later, or another one will take its place (Waters, 2005b). The symptom seems to represent the child's cry for help in that the symptom is an expression of the underlying traumatic events that the child cannot consciously express.

It is imperative that evaluators do not disregard any dissociative processing that may contribute to the continuation of symptomatology. Working in the field of trauma, it is important to be aware of the significant markers of dissociation—trance behaviors, extreme fluctuations in mood and behavior and school performance, amnesia, and depersonalization (Putnam et al., 1993).

First Four Sessions

When I resumed seeing Ryan, he did not recall having seen me when he was 3 years old. I immediately began to assess if he had any signs of depersonalization related to his chronic encopresis, and repeated failed medical and behavioral therapies. I asked him if he had sensory awareness of his soiling. He stated a complete lack of sensory awareness of bowel contractions before defecation, and often a lack of kinesthetic and olfactory awareness after he soiled his pants. He would learn about his soiling when others told him or when he changed his clothing.

Thus, he confirmed depersonalization from his waist down.

Because the body holds traumatic insults (Rothschild, 2000; Scaer, 2001), it is important to determine whether enuresis or encopresis may be a trauma response. Simple questions related to any disturbances in internal body sensations, external feeling, and olfactory senses can help the clinician determine if depersonalization exists.

In my further assessment of other dissociative symptoms, interestingly, Ryan denied awareness of internal auditory or visual hallucinations. He also denied extreme mood switches, aggressive behaviors toward others, trance behavior at school, and inserting toys in his anus—behavior symptoms reported by his mother and his teacher.

Because safety is paramount to decreasing dissociative barriers, I asked Ryan about possible further sexual abuse since he was 3 years old. He denied such. His mother also said she was unaware of any sexual reenacting between Ryan and Victor.

Given his sexual trauma, meningitis, and several sinus surgeries, I began Ryan's individual therapy with the focus on helping him gain sensory awareness. Because Ryan liked to draw, which maintained and engaged his attention, drawings were the primary modality of treatment. I asked

Ryan to draw a picture of his front and back body with connecting arrows from his body to his brain as a visual sensory integration exercise. Along with the arrows to the different body parts, I suggested to Ryan the following words and wrote them, "Nose, wake up and smell it when I have to go. Tell my brain! Wake up brain! Tell me what it means! (bowel cramps). It's OK now! You're safe!! You can feel now." On the arrow from the brain down, I wrote, "OK. I'll let you know when you have to go to the bathroom." (See Figure 4.1 and Figure 4.2.)

While he visualized this drawing in his head, Ryan imagined awakening his senses and reconnecting to his bodily sensations that alerted him to the need to defecate. He then imagined successfully going to the bathroom. Following this intervention, Ryan made improvements recognizing his bodily senses and was successful using the toilet.

In the next session, Mother noted that Ryan had had a "different look on his face." He was quiet and short-tempered one day during the week. That night, he had a nightmare and crawled into bed with his parents, saying that he had a bad dream.

Based on mother's observations, I asked Ryan to go inside of his mind to see if there was a young part of him present. He said that he saw a little one in his mind. I asked him if he would like to work with clay and make that part of himself. I explained how little ones need lots of hugging and rocking to grow up, and suggested we make a clay sculpture of his mom rocking and comforting the 3-year-old part of him. He enthusiastically agreed. I made a woman, whom he identified as his mom; he made the 3-year-old; and together we made the rocking chair. He then put the sculptured 3-year-old part of him in the arms of his sculptured mother who was sitting in the clay rocking chair. He held the complete sculpture in his hand, and rocked it back and forth at my suggestion as I indicated how important it was for that part to know he was safe, protected, and cared for by his mother. I suggested that through rocking and caring for that part, that part can grow up to be Ryan's chronological age of 8 years old. I then suggested that his mother join our session and Ryan agreed. He explained the sculpture to his mom with my help. I asked Ryan's mother to hold him as an activity to increase their attachment and the young part's attachment to his mother. Ryan held the sculpture in his hands as I talked about how he was hurt and sad when sexually abused at 3 years old. He nodded his head. I explained that with rocking and comforting, his 3-year-old can grow up to 8 years old, Ryan's age, and then join as one with him. In the next session, I asked Ryan how the 3-year-old part was doing, and he said that he grew up to be his age. We then made an 8-year-old sculpture of this part of Ryan and a Ryan sculpture. Using the two sculptures, I asked Ryan to join them together to form one Ryan. He made one big Ryan as I talked to him about how they can join together as one, reinforcing that he was hurt from the bad touches in the past but was safe now. He stated that they were now one.

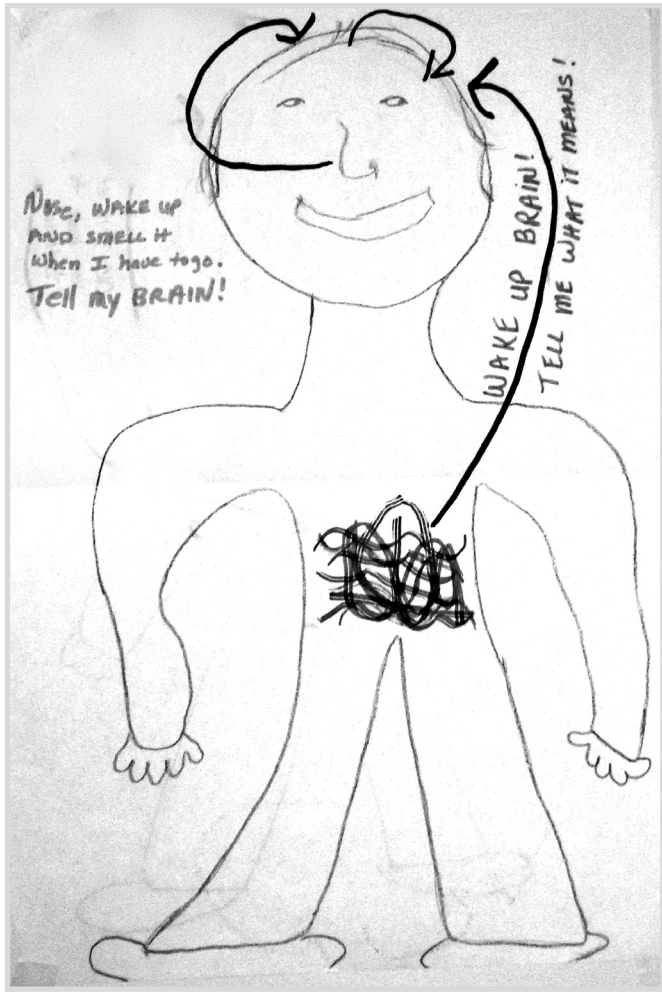


Figure 4.1 Ryan awakening his senses—front. (Used with permission.)

I have used this simple technique numerous times to age progress and integrate young states (Waters and Silberg, 1998a). Since processing traumatic events usually requires more in-depth processing before integration of a dissociative state, I wonder if this state may have been the original Ryan that had not been traumatized but separated from Ryan, a traumatized state who became the presenting personality. It is also possible that this one benefited from my earlier treatment of Ryan's sexual abuse and consequently was ready to integrate.

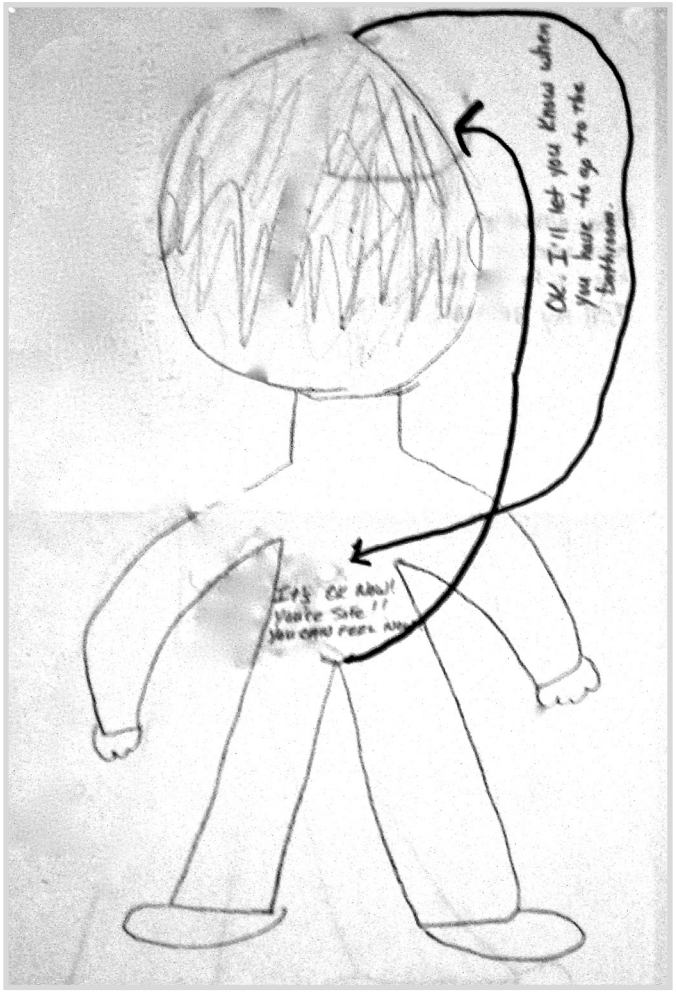


Figure 4.2 Ryan awakening his senses—back. (Used with permission.)

Parent Participation in Therapy Sessions

Ryan's parents were seen separately at the beginning of each session. Particularly early in treatment, as well as throughout the treatment course, I provide considerable psychoeducation to the parents (and the child) about the effects of trauma on their child, the dynamics of dissociation and its symptoms, and ways to stabilize the child at home and at school. It is crucial that the parents and caregivers make sense of the child's actions, display empathy toward the child, and, hopefully, be engaged in the child's recovery.

Because it was clearly beneficial to have Ryan's mother present during the session and for her to become an important ally in the therapeutic process (Benjamin and Benjamin, 1993), I asked Ryan separately if he would agree to have his mother and father, when possible, join us. He said he felt comfortable with that idea. I reassured him that, if there were a time he did not feel comfortable, it would be important for him to tell me. Fortunately, that did not occur. His mom was nonintrusive and supportive, and her participation enhanced his recovery. She observed and engaged when I solicited her involvement. Cathy became my "therapeutic assistant," which proved invaluable in several ways. She was able to witness first-hand her son's description of his dissociation and was able to learn how to identify and manage his dissociation with modified techniques at home.

Most importantly, as Ryan's dissociative states appeared in therapy, mother was often able to recognize them and express support to them. This facilitated an attachment between Ryan's dissociative states and his mother. Although, at times, Ryan had a positive relationship with his mother, there were times when he was very different and unattached. He experienced periods of amnesia related to conversations with his mother and his own behavior. Ryan's mother's presence in the sessions provided opportunities to fill in these gaps in Ryan's memory and she did so in a nonjudgmental, accepting, and caring manner. Ryan's father attended when his work permitted and he was also able to learn to decipher dissociative switches with Ryan. As the reader will learn, the parents' presence at critical points in therapy was invaluable for knowing about the extent of Ryan's dissociation and for facilitating his healing.

5th Session

Although Ryan reported that the 3-year-old had age-progressed to 8 years old and integrated, mother continued to find hidden soiled underwear. Many unanswered questions loomed. Ryan looked downward, which prompted me to ask if he felt shame. He responded that he did. I began to explain that it is not unusual to have such problems, particularly because he had received bad touches, and that our work together was to help him overcome this problem.

> Shame is a debilitating emotion that can cause one to hide from oneself to avoid this affect, which can further increase dissociative mechanisms (Nathanson, 1992). I therefore wanted to address that immediately.

I suggested that he might want to work with clay to work through his feelings of shame. He agreed. Ryan made a glob of clay representing the shame and ran over it with a car as I talked to him about how he did his

best when he was little not to feel his body because it was so scary. I asked him if he felt safe now, and he indicated that he did. I stated that was good because he can begin to feel his body now and that will help him gain awareness of when he has to go to the bathroom. I also indicated that he did the best job he could to get through the abuse when he was so little, and that his parents and I were here to help him with his fears, shame, and other feelings so he can feel better and reconnect with his body. He left the session with a stride in his walk and his head held high.

6th Session

Prior to the next session, I received a phone call from Ryan's teacher who reported that he had hit another child at school while waiting in line and then had totally denied it, falling to the ground sobbing. She said, "Ryan really didn't know he had done it." This illuminating consultation regarding Ryan's amnesia led me to realize that I needed to discuss this incident fully with Ryan and consider the possible presence of a dissociative state.

> It is important to explore with children any incidents they do not recall, so they can learn about their problematic behaviors and the possible presence of any dissociative states that may account for such behavior. I often will ask them to go inside of their minds to see if some part of them may know about such incidents. This is often the first step to breaking down the amnestic barriers between the child and the child's dissociative states, and help the child become more in control of his or her behavior.

Furthermore, Ryan's mother reported an incident when he had awoken "not himself." He was resistant to putting his ice skates on and skating (his passion) during the weekend hockey tournament, and he again had a different look on his face—"a countenance change with his eyes and eyebrows down. He was disagreeable rather than compliant." His teacher also reported to Ryan's mother that, at times, he "isn't here. He has gaps when he goes somewhere else. Even when the paper is in front of him, he will just stare at it and not know what to do." The teacher had to give him special attention to keep him focused. Mother also learned from the teacher about Ryan's hitting episode. We both agreed that I needed to further question Ryan about these problems and evaluate for further dissociative splitting.

> Ongoing collaboration with parents and teachers is invaluable for detecting dissociative symptoms, which more often occur in a child's natural milieu, rather than in therapy sessions. These symptoms can often be misdiagnosed

as attention deficit hyperactivity disorder due to the child's inattention, or oppositional defiant disorder due to the child's noncompliance with schoolwork and other tasks, as well as aggressive behaviors.

During this session, mother and I discussed with Ryan the dramatic changes in his mood and behavior. Ryan had no memory of the hockey tournament, his refusal to put on his ice skates, or his aggressive and trance episodes in school. Although Ryan denied any internal auditory hallucinations, I knew that some dissociative children may experience internally visual hallucinations of dissociated states without hearing them. I asked Ryan if he saw anything in his mind. He reported, "I see a friendly kid and he's not afraid. He looks like me." He referred to him as "Friendly Ryan."

Ryan's recognition of this dissociative state was a critical step toward Ryan understanding himself. I needed to explore the origin and purpose of Friendly Ryan and emphasize the importance of Ryan and Friendly Ryan working together cooperatively to help Ryan (Waters and Silberg, 1998b). It is helpful to have cue words to help in that process (ibid).

I asked Ryan how Friendly Ryan became a part of him, and whether Friendly Ryan had helped him when he got abused, but Ryan did not know his origin. Ryan did say that he learned about Friendly Ryan when he drew the picture of awakening his senses to his brain (see Figure 4.1 and Figure 4.2), unbeknownst to me.

I said I was glad to know about Friendly Ryan and wanted to learn about him. I explained that in some way Friendly Ryan had helped him. I asked Ryan to talk to Friendly Ryan about the incidents and let me know what he said. Ryan reported that Friendly Ryan was unaware of them. I indicated that it was important for Friendly Ryan to watch and listen at all times and that I hoped that they may learn something about these incidents and that Ryan could then tell me.

I inquired if Friendly Ryan had any awareness about Ryan's mom, who was present in the session. Friendly Ryan knew Ryan's mom and "thinks she is nice," but he did not have a mom. Ryan's mom responded by warmly accepting Friendly Ryan and expressing appreciation of him. I asked Friendly Ryan if he would accept Ryan's mom as his mom, and he agreed to do so.

I introduced the phrase, "Get it together," to be said to Ryan by his parents when they noticed he was "going away in his mind or the two of them [Ryan and Friendly Ryan] were not watching and listening together in the now." I later contacted Ryan's teacher and asked her to use this phrase, which she was glad to do.

Although Ryan could not explicitly explain the reason for the formation of Friendly Ryan, Friendly Ryan did appear to be a support or friend to Ryan, thus assuming such a name. At the time of trauma, children may develop "friends" to help them to feel better. Children often name their dissociative states by the roles those states play in their lives or by the feelings they hold.

Interestingly, I had not been aware when I worked with Ryan on awakening his bodily senses that he was seeing Friendly Ryan in his mind. This was an important reminder to me always to ask a child, when doing an intervention, not only if the child hears anything in his or her mind, but also if the child sees anything inside of his or her mind. If I had done so, most likely I would have learned about Friendly Ryan sooner. Often, young children simply do not report such experiences because they do not know they are significant, and they do not know they should be reporting such information.

Also important to note from this session is that we cannot assume that children's dissociative states identify the child's parents as their parents. Often, a relationship bridge will need to be built between the caregivers and dissociative states. This bridge can occur when the caregiver acknowledges, accepts, and understands all states of the child, even the difficult ones who carry anger and act out. These states will then be more willing to accept the caregiver and build an attachment with that caregiver. Getting all parts of Ryan to accept and attach to his parents will decrease child management problems. All of Ryan's states identifying with Ryan's parents will also aid in Ryan becoming more unified.

We still did not know, however, who was responsible for Ryan's misbehavior. I suspected that there might be another state, an aggressive, hidden state that was unwilling to be known at this time.

7th Session

Cathy reported that Ryan's aggression had escalated at home and at school. He attacked a boy from behind at school over a minor irritation. Everything seemed to irritate him. He soiled his pants during the weekend when they spent time at a hotel. He was demanding. He left his father at the ice arena and went off by himself.

Ryan's mom was having a difficult time dealing with Ryan's anger. She explained that neither she nor her husband encouraged their children to express anger, given her experience of growing up with a critical mother and her husband's experience of being exposed to domestic violence in his

childhood. I discussed with her that appropriate expression of anger is healthy. Otherwise, anger becomes displaced with violence toward less-defensible people, or in other aggressive ways. We discussed ways for Ryan to discuss his anger constructively and how she could encourage this. Mother and I had earlier discussed appropriate consequences in such situations so that Ryan could learn that even if he does not recall what he did, he still has to be responsible for his behavior. His mother took away his television and computer from Ryan for a few days for hitting a boy at school.

Ryan joined us. Mom sat quietly and observed as I explored with Ryan his behavior problems and the role any dissociative states might contribute. He said he and Friendly Ryan talked to each other, but neither was aware of the aggressive incident at school or the conversations with his teacher and his mom about his behavior. I asked him to ask Friendly Ryan if he knew anything about the hockey weekend. Ryan reported that Friendly Ryan said that he can watch what is going on because he has "special eyes and can see through things like metal and stuff." Friendly Ryan, however, did not know why Ryan was disgruntled at the hockey rink, neither did he have any knowledge about the hitting incident at school because he "was busy eating pizza." I told Friendly Ryan, through Ryan, how important it was for him to watch and listen at all times and asked him to step in if Ryan needed help controlling himself.

I also stated to Ryan that perhaps there was an angry part of him that probably has lots of reasons to feel anger and maybe took the anger Ryan had felt about the early sexual abuse. I appreciated that that part was able to take the anger for Ryan and how he must be strong and powerful—just what Ryan had needed when he was hurt. I said that I hoped to get to know that part and help that part find a way to express anger without getting into trouble.

Considering Ryan's change in countenance, continued lack of memory for problematic behavior even after receiving a behavior consequence, and the presence of two known dissociative states, I was concerned there was a hidden state responsible for the extreme change in Ryan's behavior.

Often, angry parts are hesitant to let themselves be known due to fear of rejection. Because they frequently contain the dissociated rage attached to the traumatic events, they hold considerable power within the child's internal system that they may not be willing to relinquish for fear of being hurt again. Those hidden parts may be listening. Therefore, even before the angry part becomes known, it is important to reframe that aspect into a helper. This will pave the way for that part's willingness to be known and cooperatively work on safe discharge of negative affect, better self-control, and further resolution of the origin of the anger.

> Furthermore, when dissociative children express a lack of awareness of their troubling behaviors, it can be difficult to ascertain if they are lying to avoid recrimination, or if they do have amnesia. Nevertheless, to encourage the erosion of what appears to be amnestic barriers between states and to encourage the concept of shared responsibility across dissociative states for acting-out behavior, these children need to be held accountable for their behavior with reasonable behavioral consequences (Waters, 1998).

I explained to Ryan's mom, with Ryan listening, about anger being another feeling that needs appropriate expression. We also talked about how important the angry part of Ryan was, and that it was important for his mom to accept and work with that part. Mom told Ryan she accepted that part of him that seemed so angry. She stated a willingness to work with that part so Ryan and all parts of him could learn how to get along better with her and with others.

As I asked further questions through Ryan with regard to what Friendly Ryan shared with Ryan in terms of bodily experiences, Friendly Ryan appeared, tilting his head up and shifting his weight to sit straighter. He said, "I am Friendly Ryan." His mother and I said, "Hello," and I asked him many questions about his self-awareness inside of Ryan. He said "I cannot hear you talking (from inside of Ryan) and I cannot feel or smell, but I can taste." I asked if he and Ryan both liked the same things, and Friendly Ryan said that they both liked the same food and clothes. As Friendly Ryan talked, he licked his lips, a behavior mother had noted as appearing from time to time. I asked if he felt hugs from Ryan's mom, but he said he did not. I encouraged Friendly Ryan and Ryan to stay very close to each other so that Friendly Ryan could feel mom's hug when she gave Ryan a hug. I indicated that I would like Ryan to return and thanked Friendly Ryan for talking to me.

> Although it is recommended that the therapist talk to the dissociative aspects through the presenting child in order not to unwittingly reinforce switching, at times dissociative parts will appear. When this happens, respectfully acknowledging and talking to a state is acceptable. A state is appearing for a reason that in the end may help in the child's recovery. Furthermore, if I told Friendly Ryan to go back inside without talking to him, he most likely would have felt rejected, angry, and hurt. This would have interfered with his cooperation and acceptance of my help. I now had first-hand confirmation that Ryan had dissociative identity disorder—a fact his parents had seen for some time.



Figure 4.3 Friendly Ryan's self-portrait. (Used with permission.)

I asked Ryan, together with Friendly Ryan's help from the inside, to draw a picture of Friendly Ryan as we talked. Interestingly, he drew Friendly Ryan with his tongue out (Figure 4.3).

> Even though Friendly Ryan did not verbally divulge any memory of trauma, the protruded tongue may have signified implicit memory of the oral abuse by his brother—an incident he had reported to me at 3 years of age. Because Friendly Ryan described sharing taste sensations with Ryan, the

> tongue may also have unconsciously represented his taste experience and may have had something to do with Friendly Ryan licking his lips. I also wondered if this could have been an attempt to wipe away the taste associated with oral abuse? This was a hypothesis I contemplated as we worked on processing Ryan's trauma.

8th Session

Cathy reported that Ryan had experienced memory gaps and irritability about coming here and about going to his hockey game. He wanted to just play. This, again, was contradictory to his usual behavior, as he loved hockey. He had been snappy with his brothers. There was some improvement, nevertheless. Ryan had not had any soiling accidents since the last appointment, and even though he awakened four times in the night with diarrhea, he successfully made it to the bathroom.

Ryan joined his mother and me, and reported being physically aware of the need to use the bathroom in the middle of the night. Mother asked him about his crankiness, but he was not aware of those times. I asked him to go inside of his mind and see if he could find out why he was cranky. He closed his eyes and replied that he saw a "Crabby Ryan." I told him I was glad to know about Crabby Ryan and that perhaps this part is crabby because he has some bad feelings that he took for Ryan when he got hurt. I said that I hoped to learn more about Crabby Ryan. I asked Ryan to draw a picture to symbolize how Ryan, Friendly Ryan, and Crabby Ryan could communicate with each other so that they all know what is occurring in the present (see Figure 4.4).

He drew the three of them talking on phones connected to telephone poles. Of particular significance, Crabby Ryan was all in black, and Ryan and Friendly Ryan were in bright colors. I emphasized that Crabby Ryan must have lots of bad feelings and that I wanted to help him feel better.

> Drawings can visually reinforce the importance of inner communication among parts. This is a significant step toward internal rapport building and problem solving.

9th Session

Cathy reported that Ryan had awoken during the last week with a severe migraine and threw up, resulting in hospitalization for two days. He was diagnosed with a severe sinus infection and will require surgery.



Figure 4.4 Ryan and his parts communicating. (Used with permission.)

> I recalled that it was just a year ago when he had spinal meningitis and had to be hospitalized. I wondered if his body was having an anniversary reaction to the traumatic experience of spinal meningitis, which can cause severe head pain.

Mother also reported that in the past week Ryan had yelled at Victor, the brother who had sexually abused him. There might be more memories about to surface.

When Ryan joined us, he reported that it was Crabby Ryan who had yelled at Victor, but he refused to talk about the incident. I commented that perhaps Crabby Ryan was created to carry Ryan's anger toward Victor because now Ryan was not expressing any outward anger toward his brother for the sexual abuse. As we talked, Crabby Ryan appeared spontaneously and said he was Crabby Ryan. I asked him if he carried the anger toward Victor, and he said he did. I thanked him for helping Ryan. Mother and I told Crabby Ryan that we wanted to help him to work through his anger in a constructive way so he could feel better. I explained to Crabby Ryan the meaning of the phrase, "Get it together," and asked him if he would be willing to accept the phrase from his parents and teacher

when they noticed Ryan was having difficulty focusing and controlling his behavior. He nodded. I also indicated that it was best for only Ryan to go to school and that Crabby Ryan could watch and listen from inside and help Ryan with his schoolwork from inside. He said that he would do so. I breathed a sigh of relief to know about this part and to have his cooperation. I asked to talk to Ryan, who appeared. At my prompting, Ryan also expressed appreciation for Crabby Ryan's help.

Because we were also dealing with Ryan's recent illness and hospitalization, I suggested he draw a picture of his body fighting the infection, using a hero figure to help him overcome the infection and the pain he felt. He drew Superman fighting bad germs. I also suggested that he use Superman to help him fight off the bad headaches, and he agreed. From that moment, Superman became Ryan's symbol of strength throughout his recovery and integration. Mother was quite surprised by Ryan's choice of a hero figure, because that was hers as well but she had not told him until this moment. They both smiled at each other, and this seemed to be a moment of bonding.

> It is important to have a number of stabilization techniques, such as hero symbols, to help children feel empowered. This hero figure can be used particularly when processing traumatic memories or dealing with overwhelming feelings.

10th Session

Mother reported that Ryan had been angry, impatient, and sassy with his dad at the hockey rink. On a positive note, Ryan did get stars from school all week and did not have any soiling problems or headaches.

Ryan joined us. When I reviewed the last session and showed him the Superman picture, he did not recall doing the drawing. I asked him to go inside and see what part drew the picture. He reported that it was Friendly Ryan, who said that he had wanted to draw the picture and took over without informing us. We were not aware of the switching.

> Although I continued to stress that all parts needed to be watching and listening while Ryan was present, switching among states accompanied with amnesia had occurred during the last session. Even when trauma is over and no apparent reason exists for switching of dissociative states, this can be an automatic response. Simply, Friendly Ryan wanted to draw the picture. With children, if one part enjoys doing something, that part may take over without the other parts being aware.

Because dissociative children can have personality states close in age and temperament, it is often difficult for a parent or a therapist to ascertain that a different part has taken over, particularly when they begin to cooperate. Children's dissociative states presentation can be more subtle than the more florid presentations seen in adults.

In trying to sort out who was responsible for misbehaving at the ice rink, I asked Friendly Ryan if he knew who was having problems. He indicated that it was Crabby Ryan. There was a shift in his facial expression as he displayed downward eyes and wrinkled eyebrows. Crabby Ryan appeared, identifying himself. He simply said that ice skating was not his thing. I asked him how old he was. He said he was 21 years old. I asked him if Ryan's parents were his, and he said he did not have parents. A discovery was made, however. I asked Crabby Ryan if he knew me, and he stated that he remembered coming to see me when he was 3 years old by saying, "I know you from before."

I had not known that I was treating a separate dissociative state when Ryan was 3 years old. This was a learning moment for me to inquire, nevertheless, about the presence of dissociative states in very young children even when they do not appear to behave in a "regressed way" and have not known amnesia for traumatic events, as in Ryan's case.

It was critical for Crabby Ryan to accept Ryan's parents as his. He did not want to adopt his mom this week when I asked him, because he "was doing his homework." But he did agree to consider "adoption" at the next session when both his parents would come.

It was clear Crabby Ryan was not ready to accept Ryan's mother, a common occurrence when an angry part first meets a parent. Also, because Crabby Ryan had been around when Ryan was 3 years old, he may have felt both estrangement and anger toward Ryan's parents because they did not know he existed and they did not protect him from his brother. It was most important to respect his feelings and give him space at this time.

11th Session

Both parents attended this session and met with me initially. They reported Crabby Ryan was out throughout the week when they took a hockey trip and when they attended holiday activities at a relative's house. He was

very resistant to putting on his hockey uniform, delayed opening gifts, was argumentative and disruptive, and cried. He also chose to have ham and pineapple on his pizza instead of the usual pepperoni and cheese. He was resistant to having blood drawn to test for headaches. He was very protective of his older brother, Tommy, and attacked Tommy's friend whom he perceived as being mean to his brother. Parents asked that Ryan be present but to no avail. After he was sent to the bedroom and fell asleep, he woke up in "a better mood"—probably a different state. Mom used the cue phrase, "Get it together," and invited him to use the Superman metaphor to help him pull all his parts together. He was much better behaved then.

The night they returned home from the holiday trip, Ryan woke up with another "night spell." Parents noted that Ryan "was almost asleep," threw up for 2½ hours at fifteen-minute intervals, and had a bad headache. I wondered if Ryan was in a trance state given his parents' description.

Ryan then joined his parents and me announcing that he was Friendly Ryan as he licked his teeth. He did not know how Ryan was doing, because Friendly Ryan "had been asleep" since he saw me at our last appointment. I stressed the importance of Friendly Ryan being on the same sleep pattern with Ryan so he would be aware of what was happening through Ryan's eyes. The licking of the lips stopped, and suddenly Ryan emerged and said he was Ryan. I asked about the headaches. He indicated that he and Crabby Ryan remembered having headaches, but Friendly Ryan did not have headaches. Ryan did not, however, know about the "night spells." As we were talking, there was a shift in his overall demeanor. Ryan straightened himself up and put his feet down on the floor. He bit his lip. His parents and I both noticed this shift and looked at each other. His mother asked if this was still Ryan or another part of Ryan. Crabby Ryan said it was he.

Because Ryan's parents were on the couch, I asked if he knew who they were. Crabby Ryan replied that he did not know the man but had seen the woman at the last session. Crabby Ryan said that Ryan from inside told him their names. I asked him a series of questions to see what he knew of Ryan's life. He did not know Ryan's brothers. He knew the school and grade Ryan attended. Crabby Ryan again said that he knew me from when I had treated him years ago. I asked if he knew that he shared the same body with Ryan. He said that he did not know that. I asked what he thought about this. He said, "I thought my body was a weird black with white spots, like a good luck charm." I asked him to look at his body. He did so and recognized that it was not like a good luck charm but looked like Ryan's body. I asked him if he liked to think of himself as having good luck, and he agreed. I confirmed that it is good to feel lucky. I introduced the notion of him and Ryan's parents getting to know each other and adopting each other. I explained how Ryan's parents wanted to be his parents as well, and to help and protect him. Crabby Ryan agreed to get

to know his parents, but when his dad asked him to come over and sit on his lap, Crabby Ryan declined. His parents looked very surprised, as Ryan was usually glad to sit on his dad's lap. Crabby Ryan agreed to work with his parents in a cooperative fashion and accept their help as well as mine. I asked about his name being "Crabby," and he replied, "I've always been crabby about things, but don't know what they are."

> Although Crabby Ryan did not know why he was crabby, I suspected that he might carry the anger related to the sexual abuse, even though he did not recall such memories at this time. He might also carry negative affect from other upsetting experiences, particularly the spinal meningitis. When children have used dissociation to cope with an earlier trauma, they frequently continue, when further negative events occur, to segment off similar negative affect automatically and place it with the state created for holding that affect. Perhaps this was the case with Crabby Ryan.

After this discussion, I asked to talk to Ryan, who returned. Once again, there was a noticeable shift in his posture. He curled up in the chair. I asked what had just occurred, but he did not know. I asked him to ask inside his mind to find out. He told us that Crabby Ryan told him what occurred, and Ryan reported it to us. His dad asked him if he wanted to sit on his lap. Ryan immediately went over and sat and snuggled on his dad's lap.

> It is paramount to continue to focus on breaking down the amnesia internally (between dissociative states) and externally (with people and events in the environment). Throughout the therapy, I will continue to stress that Ryan be out and that the other parts of Ryan watch, listen, and help Ryan cooperate from inside Ryan.

12th Through 14th Sessions

There continued to be many significant interventions during these sessions. Parents reported that Ryan's medical tests revealed his EEG was abnormal on the right frontal lobe, but there was no seizure activity. He was not prescribed any medication. The test for allergies was negative but would be repeated due to nasal inflammation and sinus infections. He was prescribed medication for allergies due to nasal inflammation.

Although the "night spells" were occurring less frequently, Ryan did have a few more nighttime episodes of waking with chills, shaking, being glassy-eyed, being incoherent, having a severe headache, and throwing up.

After going back to sleep, he would be fine the next day and want to play. Ryan said he recalled knowing about only one of the "night spells" but had not felt the spells. At my request, Ryan asked inside who knew about and felt those episodes. Crabby Ryan said he was the one who knew about them and had felt them.

My suspicion that the "night spells" were a form of somatoform dissociation was confirmed. Crabby Ryan was the one who had the night spells marked by considerable pain; Ryan did not have them and, until now, was unaware of them. Ryan's chronic encopresis connected with loss of lower body sensations, and a loss of smell was also a symptom of somatoform dissociation. Depending on what state is present, the symptom can appear and disappear. It is often very confusing for the clinician to understand how these symptoms can be chronic and episodic.

Diseth's seminal research (2006) sheds considerable light on the development of somatoform dissociation in children. He followed children born without an anal opening, thus requiring surgery and regular dilatation of the opening throughout their childhood. This dilatation was painful and conducted by the parents. These children developed somatoform dissociation with persistent incontinence. Although Ryan's somatoform dissociation was a result of anal sexual penetration, the outcome was the same.

I continued to stress the importance of coconsciousness. Because Superman was his hero character, I reminded him of our earlier discussion to ask Superman to help him take away his headaches. Ryan indicated that when he felt a headache coming on, he would tell Superman "to get the headache and Superman would scare the headache away."

Ryan's encopresis recurred as he reported being unaware of his bodily senses. Ryan was hiding his underwear.

There are many possibilities for these recurring problems. Traumatic processing has yet to be done. I wanted to help Ryan become more stabilized and develop more coconsciousness, internal cooperation, and control over his switching before working on trauma processing. Also, I was hopeful that Ryan would begin to recall the specifics of the traumatic memories, and I took a "wait and see" approach before utilizing strategies that may help to access such memories. I realized at this point that I needed to find a pathway to help him process the trauma still held in his unconscious memory system. Also, there may be yet another unknown state that may account for the persistent symptoms.

On a positive note, Ryan's teacher had not seen any incidents of Ryan in a trance state in several weeks. His grades were more consistently positive. Ryan reported getting help from each of his parts as he did his schoolwork. As therapy proceeded, Ryan said that he and his parts were all working together simultaneously, sharing activities (playing, reading, sleeping, etc., at the same time). He felt more rested. His dissociative states were talking in a friendlier manner to him.

Because of the peer teasing Ryan was experiencing, his doctor recommended that Ryan have plastic ear surgery to reduce the protrusion of his ears. Ryan became quite anxious when he had to have blood drawn prior to surgery. His mother suggested he imagine calling Superman, his hero, on the phone. Ryan immediately calmed down. Mother and I agreed that we needed to prepare Ryan carefully for surgery in order, hopefully, to prevent a relapse.

In session, I asked Ryan to go inside and ask Friendly Ryan if he could tell me how he became a part of Ryan. Friendly Ryan appeared, stating that it was him, and told me that he did not know why he was formed, but he encouraged Ryan to be "nice to his brothers." Friendly Ryan denied he was sexually abused and stated that he was happy. He said he was 16 years old. I asked him to imagine being on a spaceship traveling back in time to see if he could recall how he was formed and to let me know. He did not recover any information. I then validated to Friendly Ryan that he was such a helper to Ryan, being older and wiser, but it would be good if he could also be a helper by using his wisdom to join with Ryan, becoming Ryan's then age of 9 years old. Friendly Ryan was quite agreeable to do so.

Although Friendly Ryan did not recover any information about how he was formed, this technique can be helpful with children. If a child is not ready to recover the memory behind the dissociation, such techniques are less likely to be helpful.

Often, a state's age symbolically represents the role or function it is serving for the child. For example, another dissociative child viewed her powerful, perpetrator parental state as 1,000 years old. As part of the integration process, I explain to children who have dissociative states that vary in ages from the child's true chronological age the importance of eventually having those states become the biological age of the child. Because most dissociative children's states are more fluid and flexible, and are less invested in maintaining their own identity and separateness than the dissociative states of adults, it does not usually require hypnosis to age regress or age progress (e.g., older state becoming younger to match the child's chronological age, or a baby state becoming older to match the child's chronological age). This can happen spontaneously.

Crabby Ryan spontaneously appeared at that point and acknowledged that Ryan's dad, who was present at one of these sessions, was also his dad. However, when I asked about doing specific activities such as eating and talking with his dad, Crabby Ryan declined. At a later session, Crabby Ryan agreed, because "he's [dad] becoming more a part of my life," and hugged his dad.

When we talked about all his parts becoming the same age as Ryan, Crabby Ryan announced that he was aged 15 years now.

I explored with Crabby Ryan his knowledge of events. He reported that he did not know about the "bad things" that had happened to Ryan, did not know Ryan's brothers, did not know about Ryan's recent hospitalization, and also did not know why he was crabby. Because our session was concluding, I asked Crabby Ryan if he could think about what makes him crabby and let us know next week. He agreed. I asked that Ryan return, which occurred.

It appeared that Ryan had separated along affective states (Friendly Ryan and Crabby Ryan), and his dissociative states carried the affect only with no explicit memory of the trauma. It is interesting that Crabby Ryan remembered me from when he was 3 years old but, at this time, had no conscious (verbal recall) memory of the sexual abuse. Children traumatized at a young age can have varied degrees of recall of trauma events from no conscious memory to full memory.

Reframing Crabby Ryan's persona into a more pleasant state would be important in affect regulation, as names can be very influential in shaping a state's identity.

In the next session, I asked Ryan to ask Crabby Ryan to talk more about how Crabby Ryan got his name. I asked if he felt crabby because he had taken the crabby feelings from the bad things that happened to Ryan. Crabby Ryan indicated so and said that he had taken the hurt, pain, and the anger when Ryan got bad touches. Crabby Ryan did not, however, recall the details of the abuse, only that it was bad and he had taken the bad feelings. Ryan and Crabby Ryan agreed to my suggestion that it was time to give Crabby Ryan another name. Ryan named him Fun Ryan "because he is funny and tells jokes."

When Ryan acknowledged Crabby Ryan and gave him a positive name, the two of them began an important collaborative relationship—a pathway toward healing and integration.

I then suggested Ryan's favorite sport, hockey, as a metaphor for internal cooperation and coconsciousness. All of his parts agreed to this metaphor. I explained that just as Ryan had to always watch, listen, and be ready to move effectively in the defensive position when he played hockey, he could use those skills and attention to work with his states to be successful in the classroom and at home. To further reinforce this important symbolism, I asked Ryan and his parts to draw a hockey rink with the three of them playing. (See Figure 4.5.)

Fun Ryan was now willing to join with Ryan in playing hockey.

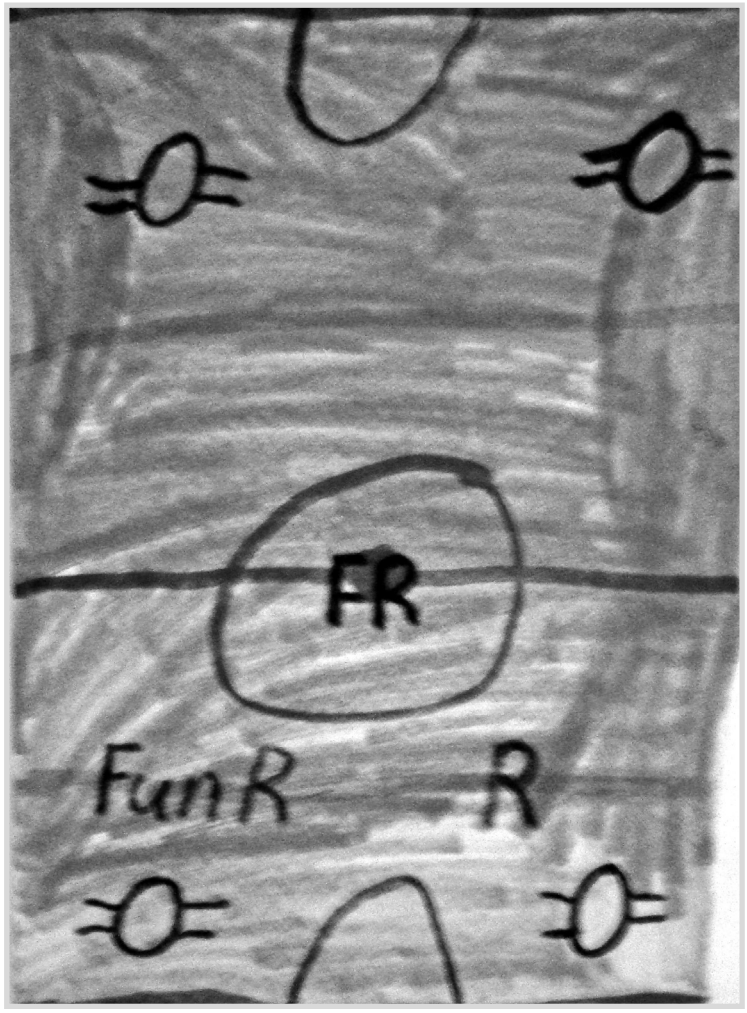


Figure 4.5 Ryan and his parts cooperating as a hockey team—using a metaphor. (Used with permission.)

Metaphors of team members playing a favorite sport or different ingredients mixed together for a favorite dessert (symbolizing parts of the self blending together) are an effective and fun means to help dissociative children understand coconsciousness, erode amnesic barriers, and promote integration. This metaphor can be used throughout treatment to reinforce unity and eventually integration—one unified child playing hockey. This final symbolic picture could be drawn at the time of integration (Waters and Silberg, 1998b).

Progress was being made with a decrease in some of the symptoms. Ryan's mother, who tracked Ryan's headaches, stated that after I worked with Fun Ryan (reframed from Crabby Ryan), the headaches and night spells ceased. We both agreed that it was Fun Ryan who held the intense affect and accounted for the seizure-like spells.

I provided an update to the pediatric neurologist and thanked her for her willingness to not put Ryan on medication. She seemed intrigued by the underlying correlation of Ryan's symptoms, and I was hopeful that she would, in the future, consider trauma as a possible factor in unexplainable medical problems and consider the possibility of somatoform dissociation.

Regardless of the progress in stabilization, Ryan continued to be encopretic and aggressive. Ryan's mom found hidden soiled underwear, and Ryan and his two states denied any awareness. He had displayed aggressive behavior in the locker room toward another player and at home with Tommy (the non-abusive brother). He denied awareness of these incidences. He had a 45-minute staring episode at a church potluck in spite of his mother's efforts to bring him back to the present. Then, instead of playing with the other children, he chose to read in the van.

I asked Ryan if he or his parts could explain the aggressive behavior and continued soiling, but they did not have any awareness. I asked Ryan to make sure that he and his states checked inside to see what might be occurring and if they saw or heard any other part of Ryan. They all denied any such awareness. They also confirmed no further abuse. Mother continued to log these incidents, but no external triggers for the soiling were evident to her or Ryan.

It is often difficult to ascertain what is operating "behind the scenes" regarding dissociative children's denial of problems. Some of the possibilities are reoccurring trauma; unknown dissociative states; continued lack of coconsciousness among known states; denial of known behavior for fear of retribution, shame, or disappointment; or inadequate processing of the original trauma. In Ryan's case, he continued to deny any further abuse, and his parents were committed to his healing and were very empathetic

with him. Ryan was very cooperative with me. Time would tell what accounted for this amnesia. I will begin to move more specifically with therapeutic interventions that provide opportunities to process the traumatic events.

I decided to do some further sensory work with Ryan (as I had done early in therapy) to help him reconnect with his body and see if traumatic memories may surface to be processed.

15th and 16th Sessions

Ryan's father brought Ryan to these sessions and provided an update that Ryan was upset at a hockey game and had to leave. Also, on several occasions, Ryan wanted to eat immediately after having a meal and was exhibiting staring behavior.

Dissociative children who have distinct separate states may eat a complete meal and then shortly afterward be hungry again and want to eat as if they had not eaten before. They may not even recall that they had eaten. Because these different states do not share bodily awareness, they may, if they switch states, overeat, sometimes resulting in obesity. They may also switch different food preferences. I was concerned that more processing on the traumatic memories needed to occur.

I asked if Ryan would like to play with clay to work on the sexual touches that had happened to him. The clay would provide some sensory processing. Ryan could form something out of clay that represented what had happened or what he had felt. He agreed to do so. Ryan formed a man with a stick and said it was a blind man with a walking stick.

I was struck with the symbolism of what he had created. I surmised that he was showing what had occurred to him—his brother had inserted a pencil into his anus. He would not have been able to see or did not want to see this abuse. I recalled that Fun Ryan had drawn himself with his eyes closed. Ryan was not conscious of the relevance of his clay figure to the details of his trauma. His unconscious mind and implicit memory system were depicting it within this safe modality.

I processed this with him by saying how this man could not see and maybe Ryan could not see what had happened to him. I asked how he felt when his brother gave him bad touches. He said that he had felt scared,

sad, and mad when his brother abused him. I asked how his body felt now, and he said, "Better." I then stated that he was safe now and that all parts of his body were safe. I listed them, starting with his eyes, ears, mouth, arms, and so forth, to private parts.

> While helping children process their trauma, it is always important to remind the child that he or she is safe now.

Because Ryan had played with clay when I treated him at 3 years old, I asked him if he recalled that time, but he did not. He also did not recall the pictures he drew for me when he was 3 years old. It seemed only to be Fun Ryan who recalled seeing me before. Interestingly, Ryan also did not recall our discussion several months earlier about his brother having sexually abused him. Ryan then left to go to the bathroom. His father noted that when I had brought up his playing with clay at 3 years old, Ryan's "eyes were glassy and his ears turned red." This made me suspicious that I was dealing with a different dissociative state. When "Ryan" returned, I asked him what his favorite activities were. He responded sledding and biking, but not hockey, which dumbfounded his dad. Because this was the end of our session, my suspicion would have to be pursued next session.

17th Session

Recognizing that Ryan's behavior in the last session had been very different, I asked him if he recalled the session in which he had made the clay figure and showed it to him. Ryan had no memory of the previous session, including the sculpture. I asked Ryan to go inside and see if he could find out who was out last week. A new dissociative state appeared and said that he was Star Ryan because "I like to look at stars." I did not notice any dramatic change in his demeanor. I thanked him for letting me know it was him last week. I asked what his first memory was and he recalled playing with blocks when Ryan was 3 years old. I asked why he had not made himself known before, and he said, "I'm the other part of Ryan and I was hiding because they might come after me and hurt me. I feel safe because no one can see me. I came out to see you because I know that you wouldn't hurt me because you didn't hurt the others." He explained that he had been afraid of Fun Ryan and had been hiding. Then he added, "I was looking at Fun Ryan and he saw me and brought me out and talked to me. He said to me, 'It's alright not to hide. I'm not going to hurt you.' He introduced me to Friendly Ryan and told me about them going swimming with Ryan. Ryan didn't know I was there." Star Ryan stated that he knew their mom (who was present at this session) and he listens to Friendly Ryan and Fun Ryan. He also said that he knew that the Ryans would not hurt him. When I asked if he knew that Ryan's brothers would

not hurt him, he shrugged his shoulders, being unsure. His mother said she had talked to Ryan's brothers about not hurting Ryan, but if that were to happen she would like every part of Ryan to come and tell her. I asked if he knew the order of the parts development, and he said that Ryan came first, then Fun Ryan, then himself (Star), and then Friendly Ryan. I asked him if he knew why he felt such fear of being hurt, but he did not know. Ryan returned spontaneously and said that the fear was because Victor had sexually abused him and Star Ryan's purpose was to hold the fear. We talked about safety measures in the home and asked Ryan to help Star Ryan with his fear by letting him know that he had not been given bad touches since he was 3 years old. I also explained that I wanted to work with every part of Ryan to help them work through their fear and to speak up if anyone did hurt them. Mom confirmed that she wanted Ryan to come to her or his dad and tell because their job was to keep him safe and help with problems.

Star Ryan's fear illustrates how dissociative states that contain fear can remain hidden for a lengthy time until they feel assured it is safe to be known. They will lurk in the background gathering information before they let others internally and externally know them. Helping all of the dissociative states to be nonthreatening (as with reframing Crabby Ryan into Fun Ryan) and assuring that the environment is safe will encourage fearful hidden states to be known.

18th Through 24th Sessions

This was a difficult time period when Ryan had cosmetic ear and sinus surgeries, and there was an increase in symptoms. The surgeries were, most likely, a major trigger for the distress from past surgeries and hospitalizations and, thus, caused regression. Ryan did considerable switching of states accompanied by amnesia, and some reenactment of his early sexual abuse, as the reader will learn.

In preparation for surgery, mother had made a Superman emblem on the T-shirt Ryan would wear into surgery (with the surgeon's approval). I worked with Ryan and his states through drawings to imagine Superman protecting them during surgery. Initially, Ryan seemed to be "fine" after surgery. However, he experienced a setback with increased encopresis, and once again "night spells" marked by some symptoms as before—severe diarrhea and shakiness, accompanied by amnesia the next morning. In spite of my work to prepare all parts of Ryan for surgery, I learned after the surgery that Fun Ryan did not know Ryan had surgery, or that his head was bandaged for a time period. Even after looking in the mirror and seeing

Ryan with smaller ears, Fun Ryan did not accept that the surgery had happened. Fun Ryan could not explain his "AWOL" but he seemed to not want anything to do with surgery and thus went into hiding, unbeknownst to us.

Mother also found an animal toy with feces on it that Ryan had inserted into his rectum. Ryan again showed extreme erratic school performance and resumed crawling into bed with his parents. After careful exploration, his parents learned that Ryan had also crawled into bed with Victor recently and then the next day he had soiled himself. Ryan and his states denied any further molestation. Parents reinforced with Ryan and Victor that they were not to sleep together and carefully monitored them. With questioning, I found that Star Ryan had been in more control of Ryan during this time. Star Ryan admitted that he lacked sensory awareness and thus was accountable for the bouts of encopresis. Star Ryan, however, did not know about the nighttime episodes.

> Mother and I took a deep breath and recognized more work to be done. I was relieved to have such a supportive and "therapeutically savvy mother," as we were able to focus on the progress knowing that this setback meant there was something yet to be discovered, not that things were hopeless. Mother continued to carefully track Ryan's symptoms to see what might be triggering this regression.

Further incidents of encopresis and Ryan crawling into bed with Victor occurred. Each of his dissociative states denied awareness of these behaviors. I asked Ryan to become the chief detective of his system in order to sort out these recurring symptoms. I asked him to draw himself and to look inside his mind to remove the barriers so that all parts of his mind were aware of his behavior. He drew a fascinating picture of himself with his body parts hanging in suspension (Figure 4.6).

There was no continuous body form. Ryan reported, "There are boxes in my head." We talked about how the boxes symbolized the "not knowing" between him and his parts and the outside world. I stressed how much better he would be by breaking down the walls. Then, he could be aware of his body, and his body and mind could work together to be able to do things. As Ryan colored the boxed shape and the space inside the glasses a light orange, he said, "There is an orange light breaking down the walls of the boxes." He again drew his tongue protruding, a common characteristic in his self-portraits. When I saw the tongue, I stated that even though parts of his body got "bad touches," he was safe now (confirmed again by him), and all parts of his physical self and all parts of him (dissociative states) can join together as one Ryan. I indicated that we could work on all of those feelings and memories and that this would help

him do that. I praised him for thinking of such a creative way to break down the walls to help him be aware of what is going on. Then, he will be able to see better, smell, taste, feel his body (particularly his lower part), and hear all that is happening in the outside world. This will help him get along so much better at school, home, and the hockey rink.

This drawing seemed to again symbolize the implicit memory of oral abuse, as well as his physical separation from his body. I again wondered if there were other hidden states that held the "secret glue" to all of this. When I looked closely at the head with all of the tiny irregular shaped boxes, I noticed six divisions in his mind. Could that mean two other parts were lurking, yet to be known? So far, there were only four that we had talked about, including Ryan.

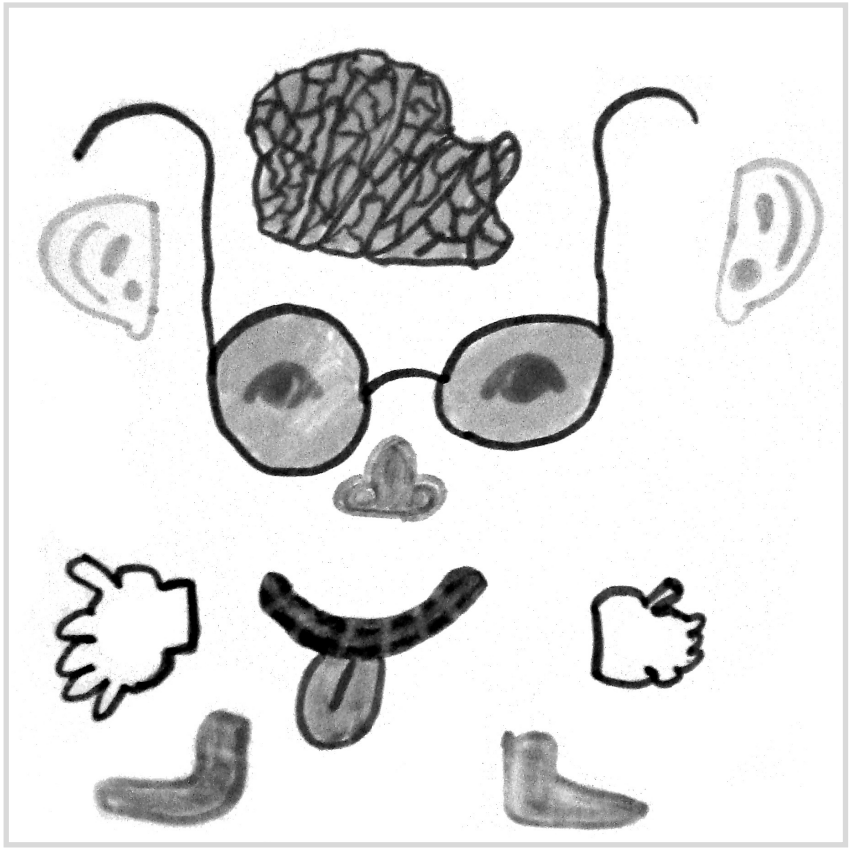


Figure 4.6 Ryan's self-portrait hanging in suspension, representing his dissociation. (Used with permission.)

Toward the end of this period, there was only one nighttime incident of diarrhea with chills but, once again, Ryan and his states, including Fun Ryan, expressed amnesia to this incident. Throughout this period, Ryan also had a sinus infection that did not respond to medication. His body was really run down.

25th Session

At this session, much to my relief, Ryan's mother reported that Ryan's personality was back on an even keel.

Ryan joined us and I reviewed with him his periods of amnesia. I showed Ryan a wind-up caterpillar toy whose jointed head and body parts turn upside down and move out of synch as a symbol of the disjointedness and lack of awareness within Ryan. I explained that, in order for the caterpillar to work, all parts of him had to work on their feelings so that they were no longer upside down (Figure 4.7).

Ryan then picked out many other wind-up toys that could represent his parts. One was a wind-up shoe (no body was connected to it) that Ryan placed far away from the others. When I played the part of the other wind-up toys who wanted to know the shoe, Ryan, who had the shoe, said, "Shoe wanted to hide cause he got tired, and the shoe got under the camel [as Ryan hid the shoe under the wind-up camel] so he can sleep, sleep, sleep." I wondered, was this a projection of what was going on inside of him, perhaps a part hiding and not ready to be known? I had more lingering questions, confusion, and no clear answers as of yet.



Figure 4.7 Caterpillar as a symbol of parts working as one. (Used with permission.)

26th Session

Ryan and his mother were seen together, and his mother reported that Ryan continued to have "night spells" of diarrhea and chills with no memory of the episode the next day. He also was soiling and hiding his underwear. There was much switching among the parts during the session as I talked with Ryan. I asked Ryan, "Did you feel it when you had to poop?" He said, "No." I asked if any part of him knew about it and to check inside of his mind to see. There was a switch as Ryan straightened his body and said, "I am the one who pooped." Noticing that movement in his body, I asked who he was, and he said, "Fun Ryan."

I asked him if he felt it when he had to poop, and he said that he did not. I asked if he could explain what might be stopping him from feeling the body, but he did not know. I asked if he and Ryan's parts could work together with me to find a way to feel his body. He agreed, indicating that all parts of Ryan were willing to work on this together. I explained that he got bad touches on his private parts and it must have hurt a lot. We will work together to take that hurt away so he can feel his body again. I thanked him for owning up to having the accidents and talking to me. I then asked for Ryan to return. Ryan's body relaxed, and I knew he had returned.

Given the degree of amnesia, I asked Ryan if he recalled playing with the wind-up toys at our last session and riding a go-cart on a recent family outing. He did not. He seemed subdued, which was unusual. He had to go to the bathroom. Upon his return, there was an immediate change in Ryan's affect and behavior, in that he was more energetic. He picked up a Hermit the Crab puppet and the crab peeked out of the shell several times. He then grabbed the gorilla puppet and had the gorilla pull the crab out of its shell. The crab then tickled the gorilla and returned to its shell. When I asked him if he knew about the fun activities on the go-cart, he excitedly told me all about it.

Once again, there was another shift in Ryan's behavior. Ryan stopped playing with the puppets and sat at my desk. He was subdued again and sat quietly. I asked who was present and he said, "Ryan." I asked him to tell me what he had just played with, but he only recalled being in the waiting room and did not know about playing with the puppets moments ago. He also did not know what part of him played with the puppets. Because it was the end of our session, I asked Ryan to try to find out and let me know at our next appointment.

> Based on the shifts I saw and the amnesia, I felt a new part had come to this session. I wondered how much this part had to do with the increased symptoms.

27th Session

The puzzle about who had been present started to be solved. I asked Ryan to do an internal check to see who had been present in the last session. He did not know who was present and none of his parts said they were here at the last appointment. I asked him to draw a picture thinking that might help Ryan figure this out. He drew two circles and put the "unknown Ryan" in one circle and himself and the known parts of him in the larger circle (Figure 4.8).

This simple exercise helped him to see what was occurring inside of him. He said the unknown Ryan was separate because he was hiding, but the others were together because they were not hiding. I asked him what he would like to say to the hiding Ryan. He said, "I told the hiding Ryan that he did not have to hide because they will all be nice to him." I said that was great that he reassured this hiding Ryan.

Then Ryan said, "He came out so that we can see him." I said that it was good to be able to see every part of him, as all parts of him are very important to help him get along and feel his body. I asked if this part had a name. Ryan called him, "Moon Ryan because there is a Star Ryan. We are like twins, and if he joins the group, he'll be one of us."

I said that was a good name and it was good to be a twin like Star Ryan because that will help them better get along. The session ended without

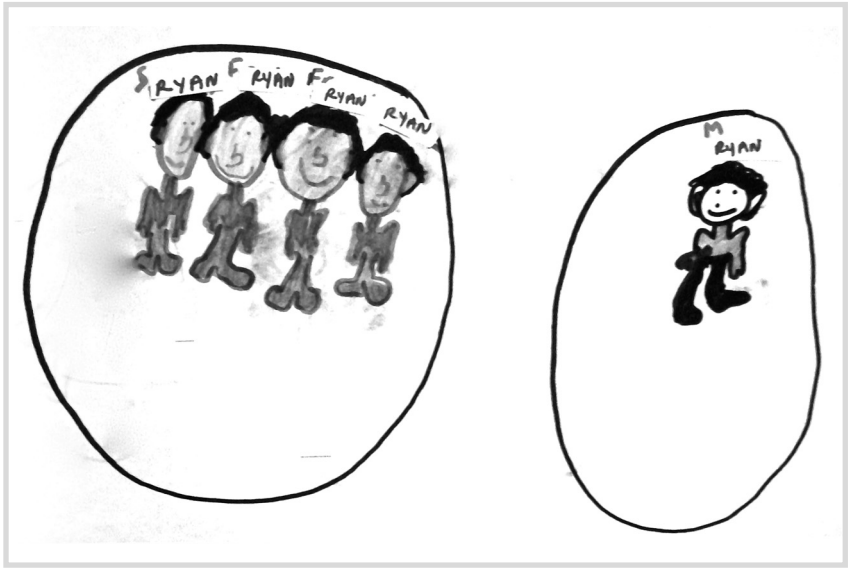


Figure 4.8 Ryan and his parts discovering an unknown part. (Used with permission.)

further time to explore the significance of Moon Ryan but with more optimism.

Ryan's therapy continued weekly except for the next couple of months due to traveling by Ryan's family and myself.

28th and 29th Sessions

Ryan's mother reported that Ryan had not needed to be on any medications for allergies in the last four months despite it being allergy season. He did, however, continue to have chronic encopresis and was hiding his underwear. Initially, he told his mother that he did not know where the underpants were but later said that Friendly or Fun Ryan hid them. When Ryan joined us, he denied any awareness of soiling but did an internal check and said it was Friendly Ryan who had soiled and hidden the underwear. Friendly Ryan appeared when I was talking to Ryan and said that he did not feel any sensation when he needed to go to the bathroom. Then Friendly Ryan had to go to the bathroom to have a bowel movement. We saw this as progress.

In the follow-up session, Moon Ryan was quickly becoming a part of the system. Ryan drew all of them together as they play "inside and talk to each other at nighttime." Moon Ryan reported that he did not know what caused him to be developed or why he came out at this time. I hoped that, in time, we would learn more about him. Much patience is required with dissociative children.

30th and 31st Sessions

Mom reported she had asked Ryan if any of his parts had gotten any bad touches. Ryan said "Yes, because Moon Ryan asked inside and told me that Friendly Ryan got bad touches, poops his pants and hides them." Moon Ryan seemed to have taken on the role of reporter, but this was new and contradictory information. Friendly Ryan had initially denied being sexually abused and had said he held only good feelings. Upon further clarification in therapy, Friendly Ryan said that he actually took only the bad feelings from Ryan, when he experienced the sexual abuse. Friendly Ryan agreed to draw a picture of his feelings about the abuse at the next session.

> It is important to accept what dissociative parts say, even if it contradicts earlier reports. Friendly Ryan may not have wanted to tell us earlier that he had taken the bad feelings of the sexual abuse and only wanted to deal with positive feelings. He also may have blocked out the taking of the bad feelings of the sexual abuse until now, when he could manage them. It is

more important to focus on helping him and the other states to process the feelings, and not focus on the validity of earlier reports.

Furthermore, I wondered if Friendly Ryan's encopresis was his attempt to release painful ("bad") feelings through soiling—a symbolic way of trying to get out not only the feelings, but also the pencil that was inserted by his brother. When Friendly Ryan hid his underwear, he appeared to have some shame—a common response.

On a positive note, Ryan's mother reported that he had gained weight this summer and increased three sizes compared with his small size when I began to treat him. Mother also noted that Ryan had not had any "night spells of diarrhea and chills" for two months—a milestone.

When children spend so much time shutting down frightening memories and unwanted feelings and thoughts, energy needed for developmental milestones (including growth spurts) can be depleted. I suspect that as we worked on his trauma and dissociative states, his endocrine system improved as well. Certainly, Ryan had exhibited much of his trauma through somatic symptoms.

32nd Session

Friendly Ryan spontaneously appeared, licking his lips, and drew an astounding picture that seemed to represent the sexual abuse. This picture symbolically portrayed a human form being anally penetrated. Friendly Ryan drew this apparent reenactment by making colored shapes that linked together. His mother and I sat silently spellbound (Figure 4.9).

When I asked Friendly Ryan to tell me about the picture and what he felt in his body, he only referred to the shapes and not the complete figure. He described that each shape had a particular feeling and proceeded to write down what the feelings were for each shape. At the top of the figure, where he had drawn a long rectangle that seemed to resemble the top of a hat, he wrote "bad feeling." The triangle below that looked like the brim of the hat he labeled "sad feeling." It seemed that the hat represented his sadness lingering over him. The face represented by a circle was black, and Friendly Ryan called it "inbarst [embarrassed] feeling." He seemed to want to hide his face—not be seen. He labeled the small green rectangle that appeared to be the neck "anger," and the long rectangular shape below the neck which appeared to be arms "ashamed feeling." He labeled the heart-shaped figure below the arms "Hart [hurt] feeling." His heart was

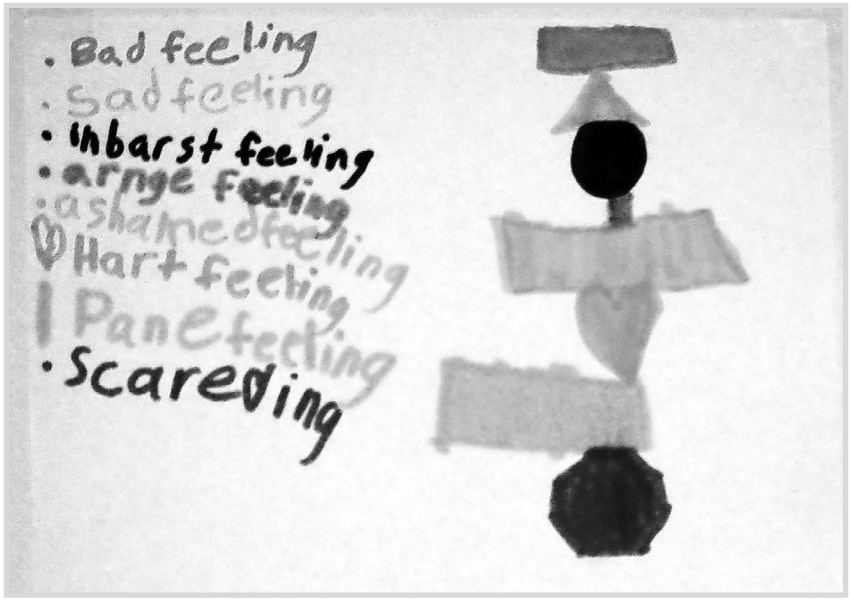


Figure 4.9 Ryan's symbolic representation of anal penetration. (Used with permission.)

very hurt by what happened. Then, he drew a yellow rectangular shape that looked like it was a pencil being inserted into his anus (matching the earlier report of the sexual assault), labeling it "pane [pain] feeling." He was letting us know how much pain he felt. Below that was a blue stop sign on which he wrote "scared feeling." The symbolism of the stop sign clearly depicted Friendly Ryan's desire to have the assault stop. He did not see that he had drawn a symbolic representation of anal penetration. We talked in depth about all of these feelings as I stressed that all parts of his body, particularly his private parts, were healing from the bad touches, and he and his parts (dissociative states that I named) were now safe to reconnect to his body and to feel again.

When Friendly Ryan drew this picture, his mother and I were mesmerized by what he depicted. We gave each other a knowing look. We realized he had drawn himself being sexually assaulted—what he had reported to me when he was 3 years old. He only knew (explicit memory) that he got "bad touches," but his implicit memory system expressed the details of the "bad touches." I did not tell him what we saw in the picture and his mother

followed my lead. He was not ready to have that in his conscious, explicit memory. The importance was that he was able to draw it without "telling" about it, and our job was to help him process this traumatic experience. Drawings are projections of the unconscious process and can depict nonverbally that which is too threatening for the child to express verbally (Kaufman and Wohl, 1992).

This was truly a pivotal healing moment. I was encouraged that we were now moving through the middle phase of treatment—processing traumatic memories—and Ryan was on his way to recovery.

33rd Through 35th Sessions

There was much progress over these three sessions in spite of Ryan continuing to have bouts of encopresis.

I explored with him his feelings regarding soiling and, understandably, he replied, "Embarrassed." I talked to him about how children who get bad touches on their private bodies have problems with soiling and not feeling their bodies. I said we would continue to work on the bad touches and help him connect to his body. I asked him to again draw a picture of himself and what he felt when he got bad touches and how his body felt (Figure 4.10).

He drew another illuminating picture of what appeared to be a depiction of oral abuse and his separation from his body. He drew a figure of himself with his tongue sticking out and his eyes closed reporting, "to zap the embarrassment feelings away." Then, he requested scissors and proceeded to carefully cut the head from the body, and then cut at the waist separating the lower body from the upper body. Then, he asked for tape and meticulously taped his body picture back together with no signs that the picture had been cut apart. I told him that it was good that he and his parts bring the mind and body back together. That will help him and every part of him to feel his body to prevent further soiling.

I truly suspect that he was unconsciously and powerfully depicting his response to the oral and anal penetration, as well as the mental and physical separation that occurred at that time. It was too difficult for him to have in his conscious memory the details of the assault, but his closed eyes with his tongue protruding seemed to show his response to the traumatic event and his desire to "zap out" not only the feelings, but also the image of what had been done to him. He was able to demonstrate how overwhelmed he felt by it all, and how he separated from his body by cutting his head from his body and then cutting his body at his waist. He was telling how he found a way to escape. The symbolism of him meticulously taping back together

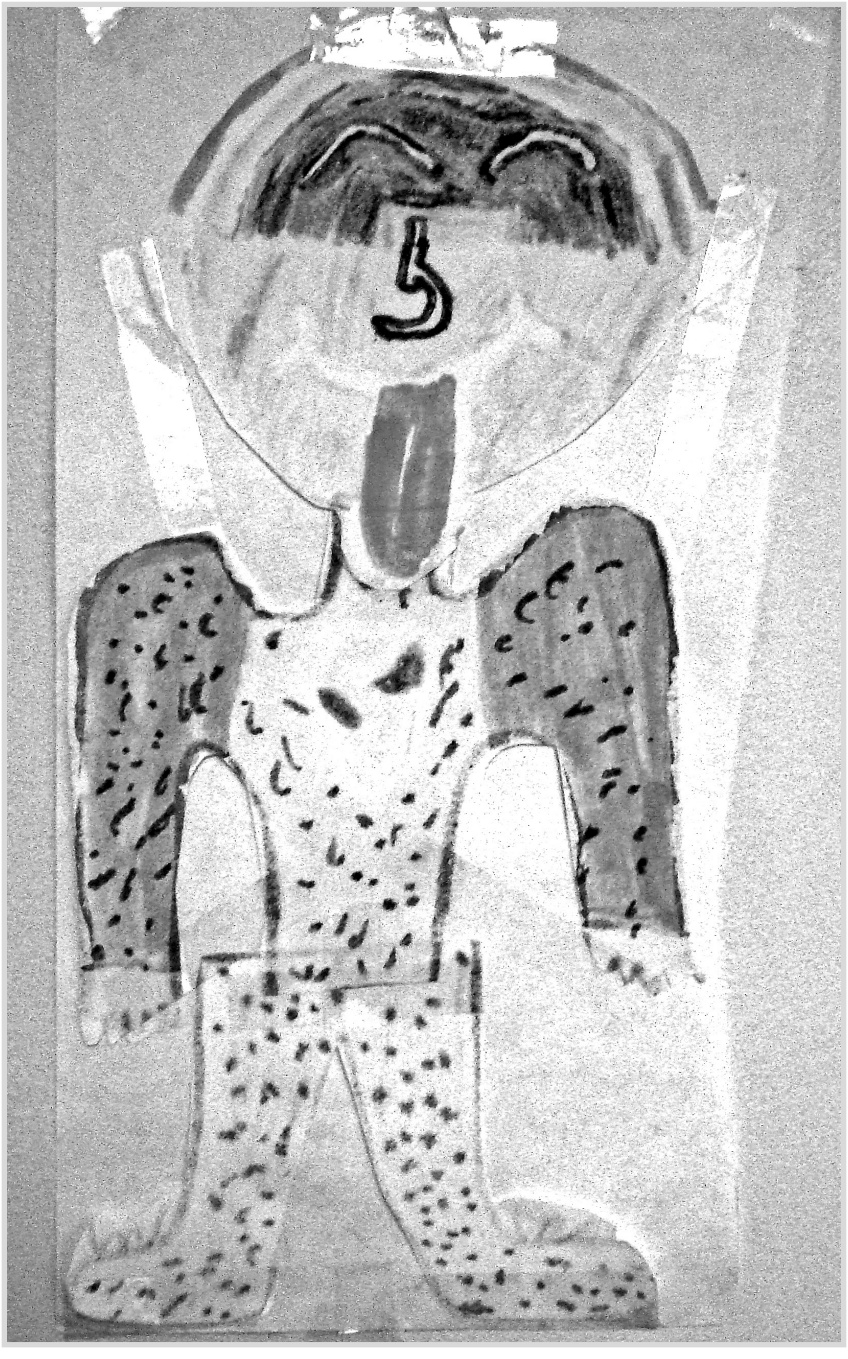


Figure 4.10 Ryan's self-portrait of oral abuse and separation from his body. (Used with permission.)

> his self-portrait was his endeavor to reconnect his mind and body—a frequent message that I had given him which he hopefully would be able to do.

Interestingly, he also referred to this drawing as a "clown because he is funny." I noted what he said and how it is fun to be a clown. I then talked to him about his hero figure, Superman, who could help him and all parts of him release the feeling of embarrassment and other feelings. Superman could help him feel his body so he would be aware when he had to use the bathroom. Ryan then referred to this figure as Super Ryan, identifying himself as a hero figure. I used this opportunity to talk about his own power to heal his mind and body, bringing them back together. I suggested he imagine Superman's powers helping him do so.

When Ryan's soiling continued, Star Ryan took responsibility and reported that he did not have any sensory awareness. He reported that Moon Ryan hid the soiled pants—a joint venture of helping, of sorts. Mother reported that Ryan had been switching frequently at a friend's house and also at home. He was also behaving like a clown. When I asked about that, Ryan said he had a clown inside him. I then asked him to draw what the clown might be feeling. He drew an outline in black of a person's shadow, stating that the "shadow is the clowning part of me." He again drew colored shapes inside the figure to depict various feelings that he labeled. He talked about being particularly afraid that the kids at school would find out about his sexual abuse, and that he was acting like a clown so people would think he was funny and not think he was sexually abused. He did say, however, that he wanted to stop "being a clown and act like a regular person." I asked him to do something for the scared feeling in the picture, so he would not be scared anymore. He then began to black out the scared symbol (blue circle located on the chest area) and proceeded to do that to the other shapes as we addressed each of those feelings. He said, "I shrunk them down." At the end, there remained only small colored spots, depicting a small degree of the remaining feelings—scared, sad, and ashamed. The other feelings—embarrassed, hurt, and pain—were blacked out, no longer felt.

> It seems that Ryan was reporting that, on an implicit level, he was healing from the aversive somatic sensations of the sexual abuse.

Significantly, Ryan had felt embarrassment in his genital area. I continued to talk about how normal those feelings were and why he felt those particular feelings. At the end of the session, he responded that the person "feels better. He's not scared. He is fun and playful." (See Figure 4.11.)



Figure 4.11 Ryan's shadow figure symbolizing feelings in his body. Only scared, sad, and ashamed retained some color. (Used with permission.)

36th Session

Ryan reported that his parts "saw someone snooping around two nights ago when Ryan was sleeping and they took a walk." They had also been aware of someone when Ryan drew the "clown picture." I asked that he check inside, and Ryan said that they all see someone who is "friendly and

nice." Ryan named him "Super Ryan" because recently when his mother woke him up, she called him Super Ryan. Ryan also referred to himself as Super Ryan when he drew the clown picture (the symbolic drawing of oral abuse, Figure 4.10).

Super Ryan suddenly appeared and identified himself. He had a rather confident air about him. He said he knew me because he saw through Ryan's eyes and my name is on my door. I gathered information about his awareness. He did not know about the clown picture Ryan had done, or that he shared the same body as Ryan. He did affirm, however, that he had seen the other parts of Ryan walking when they had seen him. He said he was the same age as Ryan, knew Ryan's family, and liked to play the same sports as Ryan. I showed Super Ryan the clown picture and he confirmed that was him. He did not know why Ryan came to see me, but Ryan had told him about the bad touches. Because we had been working on sharing sensory awareness across all dissociative states, I asked him if he felt Ryan's need to have a bowel movement and he confirmed such. I indicated that was very important and perhaps he could help the others also feel Ryan's body when he had to use the bathroom. Super Ryan said he would help. I thanked him and stressed how important that was. I also talked about the importance of all of them coming together as one with Ryan as they work through the issues that had caused them to be separate from Ryan.

Super Ryan drew an elaborate and colorful picture of himself with bulging eyes, large ears, an Indian headdress, and a cape (Figure 4.12). He reported, "The headdress means protection of animals. The jewel in the middle of my forehead makes me remember where people are so I can save them. The number 6 on my nose means that I saved 6 people." He named friends in the neighborhood, but interestingly, Ryan and his states totaled six. He further said, "The 'S' on the shoes helps me know that those shoes are mine. My suit pops out so that others can see me. My eyes pop out, that gives me special powers so that I can see everything." He also explained that his "body can split down the middle so that one side can go one way and the other side can go the other way to save somebody." Given that he had split from his body, I expressed concern about the body splitting, and he said he would only do so in case of an emergency to save someone. I said it was better to use the whole body to save someone as one Super Ryan and that way all of his senses could be used. I also reviewed with him the many helpers in his life who could assist Super Ryan and that splitting off was no longer necessary. Of significance, there was no protrusion of his tongue.

It is common for children who dissociate to have an identified hero/rescuer, and Super Ryan seemed to have taken on such a role. Furthermore, Ryan's family had strong religious beliefs of helping others and participated in

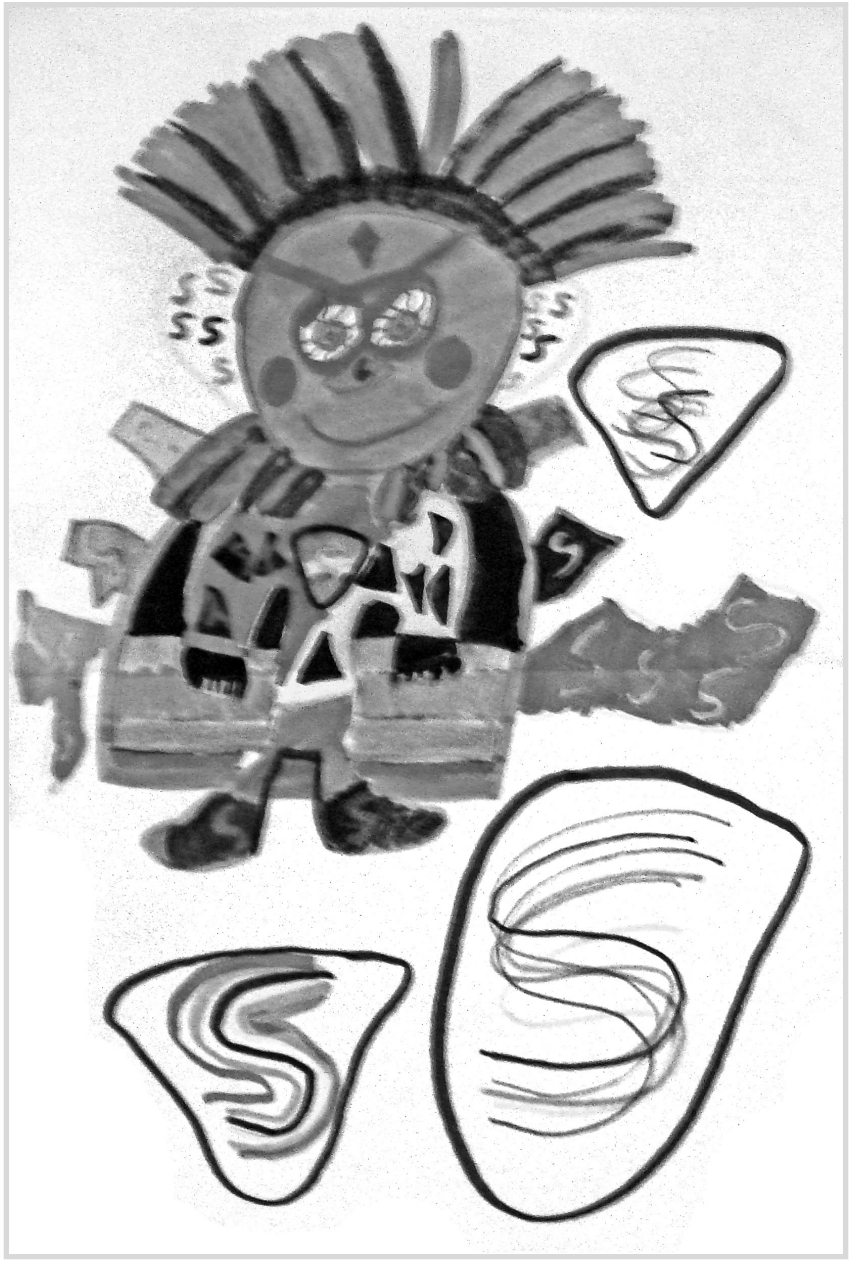


Figure 4.12 Super Ryan's portrait. (Used with permission.)

missionary trips. It appears that Super Ryan's identification as a helper and a savior seems to have been derived also from his family's experiences.

When Super Ryan said that he would split off to save someone, I wondered if that was his way of saying that if Ryan experienced another trauma, he would have to split off again to survive. It is important with children who dissociate to reinforce that there are helpers in their lives now and that dissociation is no longer necessary.

Super Ryan's description of his garb seems to be a symbolic and powerful representation of his striving toward saving Ryan (actually, himself) and assisting in integration. The headdress might represent the development of the meta-cognitive self that reflects and oversees what is occurring for self-protection. The numerous "S's" (standing for Superman) on his ears, shoes, and garb, including the symbol of Superman on his chest, appeared to signify power and connection to his body. His bright and open eyes seemed to represent visual openness and clarity. I suspect that because this self-state portrait did not have a tongue protrusion, this part was not involved in the trauma.

I was hopeful that we were getting closer to resolution of trauma and integration.

37th Through 42nd Sessions

After the emergence of Super Ryan, Ryan made considerable progress toward integration. Super Ryan reminded all of Ryan to work together on all sensory levels, and Ryan reported that all of his parts were experiencing a significant improvement in hearing, tasting, and feeling. When Ryan was administered a shot by a nurse, he cried, whereas previously he had felt nothing. He felt his body's need to defecate and stopped having accidents. Ryan's school performance was more consistent.

I continued to remind all parts of Ryan to work toward integration, emphasizing his current safety and support from his parents and me. They all agreed, including Super Ryan, to join with Ryan as one and they indicated that they were doing so. These improvements were indicators that Ryan had processed much of the trauma through symbolic artwork and was in the process of integrating.

43rd Through 52nd Sessions

Because we were seeing more signs of integration, Ryan was seen bi-weekly and then monthly. During this time period, however, there was a brief setback that in some ways was amusing and also typical of dissociative children.

Ryan spaced out again in school, necessitating his teacher to use the cue words, "Get it together," to bring him back to the present. He had several soiling accidents again (including at the ice rink, which was unusual), and was disgruntled and falling a lot when playing hockey. Once again, there was some switching among his states as Friendly Ryan, an unskilled hockey player, had played hockey. Star Ryan admitted to soiling. Further amnesia and switching occurred when mother and Ryan had stood for two hours to view the Stanley Cup (prized hockey trophy), but Ryan had no awareness of the event. Friendly Ryan and Star Ryan took control and left out Ryan, who was quite dismayed at missing out on this special occasion. In exploring the switching, Friendly Ryan and Star Ryan admitted to feeling some jealousy toward Ryan regarding playing hockey and seeing the Stanley Cup. They had decided to take control and partner together to assure that they could have these experiences. I again stressed that they and all parts of Ryan can have these experiences by watching and feeling through Ryan. Furthermore, if they work in partnership, they will be able to be aware of their body to prevent any further soiling accidents. I was perplexed as to what caused this regression, as no further abuse occurred, and the environment was stable.

When I talked to Ryan, I asked him to check with each of his states as to what might be bothering them. Ryan told me that Super Ryan "was gone helping to save other people." I indicated that an "emergency message" needed to be sent to him immediately to return and stay, as his help was required. I emphasized to Ryan that all of his parts needed to come together as one with him and that all parts were part of the package, including Super Ryan, who seemed to be the "super glue."

> It is not unusual for children to say that a part went on vacation or somewhere else. Children can develop elaborate internal worlds that may incorporate the family's values, in this case the value of helping others. Super Ryan was the part that held this value. Perhaps that was why he also appeared to be the "super glue" that could hold Ryan together (in other words, help Ryan). Super Ryan's presence was critical to complete the sensory integration.

Mother and I agreed that significant healing had occurred and that now was the time to confront Ryan about taking responsibility for himself and being in control. We had a long discussion with Ryan and his parts about how only Ryan was to be out and responsible. We valued them, and it was time for them to join with him so that life for Ryan with them inside him as one could be more successful. I asked Ryan to go inside and have a meeting with his parts and come up with some rules about how to function. They agreed on the following: (1) only Ryan is to be out and the others will watch and listen from inside and help Ryan; (2) all are to stay

connected to the body and use the toilet; and (3) any problems that the parts have will be talked about in therapy so that they can work on staying together. I praised them for making these important rules.

In the follow-up session, Ryan confirmed that Super Ryan "returned" and understood that he was an important part of Ryan. Super Ryan agreed "to stay" and work with Ryan and his other parts toward becoming "one with Ryan."

Ryan began to show consistent progress. There was no more switching among states, and he demonstrated integrated memory and sensory awareness. He showed consistent affect regulation, and performed well in hockey and in schoolwork. He had no further incidents of encopresis. His night spells had ceased for the past six months. He had one incident of a brief sinus infection when he swam in contaminated water but responded well to the antibiotic. In the past, Ryan had been unresponsive to medication, most likely because the health problems were connected to the unresolved trauma and somatoform dissociative response. At the end of this two-year treatment, Ryan had grown three sizes and had become a strong, healthy child with a strong attachment to his parents.

As mother and I noted these changes with Ryan, he added that all parts of him were now one with him. We praised him for all of the hard work he had done. I asked him to draw a picture of himself, and he did so looking very confident, with no tongue protruding (Figure 4.13).

Conclusion

Several important points can be derived from this complicated case study. Ryan had developed a plethora of convoluted medical and medical-like symptoms, as well as marked changes in his demeanor and behavior over a five-year period. These symptoms occurred after Ryan's first course of treatment was prematurely terminated at age 4 years and when he reentered therapy at age 8 years. Ryan's sudden facial, behavioral, and mood changes could have easily been ascribed to his fragile health—chronic sinus infections, spinal meningitis, and "night spells" that were thought to be a form of seizure disorder. If that had been done, the etiology of his symptoms (the early and severe sexual abuse that resulted in DID and somatoform dissociation) would have been overlooked and, consequently, untreated. Most likely, Ryan would have continued a life full of chronic medical and psychological problems with numerous medications and failed recovery.

This case points to how easy it is to overlook dissociation in young children, because, as with Ryan at age 3, there were no clear signs of splitting (memory problems or dramatic changes in his demeanor; e.g., "regressed" babyish behavior/state). If Ryan's treatment had not been discontinued before I recommended, I might have been able to detect the presence of some fragmentation. I later learned when Ryan was 9 years old that Crabby Ryan had recalled seeing me at 3 years old. While it was



Figure 4.13 Ryan's integrated self-portrait. (Used with permission.)

possible that Crabby Ryan had not fully developed into a separate state at that time, this case example hopefully will encourage clinicians carefully and continually to explore dissociation in young abused children, looking particularly for signs of depersonalization, as well as somatization. We know from ongoing research that young children are more prone to dissociation when faced with sexual and, in particular, anal trauma (Diseth, 2006; Hulette et al., 2008).

Deciphering Ryan's medical symptoms from nonmedical symptoms was important diagnostically. His physical health seems to have been

compromised by his early trauma, and I suspect this contributed to his medical problems. With what appeared to be a weakened immune system, Ryan was unable to respond successfully to surgeries on his sinuses and two bouts of intravenous antibiotics. The fright and pain from his recurring sinus infections and spinal meningitis most likely contributed to his further dissociation.

This study points to many important factors to consider in similar "medical" cases. When Ryan exhibited florid symptoms of dissociation at the beginning of his second treatment, it was crucial to consider that his "night spells" might be part of dissociation, particularly somatoform dissociation, rather than represent a seizure disorder, which would require medication. Consultation and collaboration with his pediatric neurologist proved to be constructive, as his doctor was able to consider another plausible explanation for his symptoms and agreed to defer prescribing medication. Aside from Ryan's prescriptions for his sinus infections, he was not on any other medications during my treatment of him. As I learned in therapy, Crabby Ryan primarily experienced the night spells. They were an expression of the pain and anger he experienced from the sexual abuse.

Ryan's somatoform dissociation—night spells, unexplained painful symptoms, and encopresis (the result of a loss of olfactory and kinesthetic awareness in his lower abdomen)—was not resolved until all of his dissociative states were known, the trauma was fully processed, and Ryan integrated. With the exception of Super Ryan, Ryan and his states had experienced, to varying degrees, these somatoform symptoms. Much patience and diligence were required to unravel the knotty influences on his persistent symptoms.

During the second treatment episode, Ryan had little explicit memory of the sexual trauma—only that it had happened. This case points to how valuable nonverbal interventions, such as drawings, can be for safely uncovering traumatic material and dissociation (Cohen and Cox, 1995; Kaufman and Wohl, 1992). Ryan was able to successfully process what his implicit memory depicted in his art.

Finally, and importantly, Ryan had an astute, caring, empathic mother who was able to assist in and witness her son's recovery. She was clearly my therapeutic partner. She and her husband made sure their environment was a safe place for Ryan following his disclosure. This was paramount for him to be able to begin the process of eroding the amnesic barriers of his mind. Living with his brother, Victor, who had abused him, was certainly a trigger for Ryan even though Victor, following his successful recovery from his own sexual abuse, did not exhibit any further sexually reactive behavior with Ryan.

Ryan's parents were relieved finally to understand what they had been seeing with their son, but what they had felt helpless to change until participating in his treatment. As they accepted all parts of Ryan and

supported his recovery, the attachment between them strengthened—a critical element in Ryan's healing.

Ryan, who is currently in his twenties, graduated from college and is gainfully employed.

Editor's Comment

Frances Waters describes a complex case of an 8–10-year-old boy who presented with somatoform dissociation together with DID. A major challenge with this case was to differentiate between what may have been actual medical symptoms and what may have been a nonorganic (emotional) symptom expressed through the body. As Waters explains, when nonorganic symptoms are contained within separate dissociative states, they cannot be eradicated until the dissociated states that hold the symptoms are known and become integrated, thus allowing the child to be aware of what is happening in his or her body.

Ryan's case also illustrates what happens to a child when the initial treatment is discontinued before the trauma is completely resolved. As future negative experiences occur (e.g., illness, hospitalization) and the child again feels vulnerable, the original feelings of vulnerability are likely to be retriggered, causing further dissociation and the development of additional symptoms.

Waters introduces us to her "Quadri-Therapeutic Model for Treatment of Dissociative Children" and encourages us to take into consideration what we have learned about attachment, child development, and family systems, as well as about dissociation, when working with a child who dissociates.

Because of Ryan's persistent symptoms, Waters checks throughout the therapy with both Ryan and his parents regarding safety issues. This describes so clearly that, even though trauma therapy is a three-stage model—safety and stabilization, trauma processing, and integration—work related to each stage is going to overlap with the other stages.

As Waters works with the dissociated parts, she asks the child "to check inside." She presents this as clearly preferable (the concept of "all-being-one" is implied from the beginning) to working directly with dissociated parts. However, when the child presents a part directly, she shifts and accepts what is presented. Waters warns us that, as therapists, we need to be constantly alert for body position changes, facial expression changes, voice changes, attitude and preference changes, as well as amnesia, as indicators of dissociative shifts. She clearly illustrates an attitude of acceptance and respect for all of Ryan's presentations. Even though what a child part says may contradict what was learned earlier, it is that part's perception and it needs to be accepted with the realization that that part is not yet strong enough to process all of the trauma.

Considerable time is spent helping Ryan become more aware of the daily problematic behaviors, for which he was amnesic, as a way of working

through the barriers between self-states. Although Waters knew about the early sexual abuse, she did not pursue that topic until Ryan, through his art, was able to access the parts holding the trauma memories.

The question of hidden parts, first addressed by Baita in her description of Dalma, reappears in the story of Ryan's treatment. Waters provides considerable reassurance and suggestions that Ryan can now feel and respond to his bodily needs, yet little to no change occurs in the symptoms. Waters speculates numerous times regarding hidden parts and works to create a welcoming setting that eventually enables these parts to develop trust in the external world.

As each self-state or part appears, Waters asks about the age of the part, when it was formed, why it came into being (what required the splitting off), what the function of the part is now, and how much knowledge the part has of Ryan's present world, including the parents. She then moves on—making sure the part is aware of present safety, building an attachment to the parent, recognizing the positive role the part played in the past, thanking the part, having the part either progress or regress in age to Ryan's own age, and then suggesting a new supportive role within an integrated self.

Waters engages not only the parents but also Ryan's known dissociated parts as "therapeutic partners" in the healing process. She asks the parts to check around inside as to what is happening and, in one situation, to have a meeting together and come up with some rules for the system. These requests reinforce that the child is all one and is responsible for all of himself.

The important role of Ryan's mother in this therapy needs to be acknowledged. Because of his mother's own emotional stability and the early secure attachment Ryan appears to have had with his mother, Waters is able to work in synchrony with the mother. The mother is able to understand recurrent symptoms as indicators of more work to be done, rather than failure of the therapy. Whenever possible, this is the preferable way to work. As we saw in Chapter 2, this is not always possible but should be aimed at.

Although therapy with a child who has separate self-states (DID) is usually shorter than therapy for adult clients with DID, it cannot be referred to as "short-term" therapy. (Marks's therapy described in Chapter 3 was exceptional and had been preceded by an earlier therapy directed toward strengthening attachment.) The length required for Ryan's therapy likely reflected not only the severity of the dissociation and the development of somatoform dissociation, but also the occurrence of multiple traumas (sexual abuse plus medical problems and hospitalizations).

Schore (2009: 118) described somatoform dissociation as a "stress-induced disconnect between right brain CNS (central nervous system) and ANS (autonomic nervous system) systems." Waters recognizes the important role of the right hemisphere in early memory, in the development

of self-awareness, and in the development of dissociation (Schore, 2012, 2013) as she encourages the use of nonverbal processing (e.g., drawing, working with clay) to access the trauma being held outside the awareness of the dissociated parts which were, at that particular point, participating in therapy (see Chapman, 2014). After Ryan creates a drawing, Waters very gently encourages Ryan to add words or talk about what he has drawn, thus enabling implicit memory to start to be processed explicitly (see Brewin, 2005). She encourages Ryan to become aware of whatever dissociated part may be holding further memories. She urges Ryan to become more attuned to (integrated with) his somatic processes. As recommended by Perry (2006) and Perry and Dobson (2013), Waters encourages activities appropriate for the age at which trauma (and the initial dissociative functioning) occurred, as well as involvement of the many systems in which Ryan was involved (family, school, medical).

Although Waters does not refer to any of the conceptual models discussed in the Chapter 1, we can recognize several of the concepts included in affect avoidance theory (Silberg, 2013), as well as the structural dissociation model (van der Hart et al., 2006). Waters notes early on that Ryan's dissociation appeared to have occurred between affect states with different parts holding different emotions (see Silberg, 2013). As "explorative work" continues and Waters makes contact with a part-state that holds the old hurtful memories, it is "Ryan" who tells her that the purpose of this part was to hold the fear of being sexually abused. As these states (referred to as EPs, in the structural dissociation model) are accessed and understood, and as Ryan, with Waters' encouragement, develops more direct communication with the states, they merge together with him (in structural dissociation terminology, this would be a decrease in the ANP's phobia for those feelings and memories). Waters stresses the importance of Ryan establishing a positive connection with each part of himself and thanking each part of himself—an important part of processing emphasized within the structural dissociation model. Putnam's (1997) emphasis on the importance of internal linkages between states has clearly influenced Waters' therapeutic work. Waters helping Ryan rename the dissociated parts that had early on protected him from feeling the traumas but now were dysfunctional, in that he was unable to know when he needed to go to the bathroom, with more positive terms reflects the emphasis of Watkins and Watkins (1993) on shifting from pathological dissociative states to healthy ego-states.

Ryan's dissociated self-states experience different attachment patterns with his parents. Some of them have no knowledge of the parents. We can only speculate how Liotti (1999) might classify this attachment pattern —perhaps, as "detached attachment." All parts gaining knowledge of the parents, and feeling safely and securely connected to them, was an important part of the therapy.

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5 Joey (11 to 12 Years Old)—Moving Out of Dissociative Protection

Treatment of a Boy with Dissociative Disorder Not Elsewhere Classified Following Early Family Trauma

Sandra Wieland

Referral

My reaction to the call was fascination and fury.

Joey's birth aunt/prospective adoptive mother called me to ask about therapy for her 11-year-old nephew/son. He was exploding and out of control both at home and at school. At other times, he would be the most loving boy. At times, he would cause chaos in the classroom (hitting and swearing), and at other times he would hide under his jacket, or run out of the class and out of the school—sometimes returning and sometimes going home. There was considerable lying. Another problem had been the continual love notes and comments he had made to a girl in his class. Eventually, the school moved him into another class. At other times, he would take a leadership role in the class and would work quite well. Despite all this, the teacher and the principal were both fond of him and very supportive of him. This is what triggered the fascination—what an interesting child to work with.

When Joey was 2 years old, his birth father killed his birth mother. This occurred in the home when Joey and his older sister (5 years old) were "asleep." They were taken that night to the home of some relatives they barely knew and then the next morning to their aunt (mother's sister) and uncle's house. Since that time, Joey and his sister have been part of that family—Mom, Dad, two older brothers, birth sister, and himself. His birth father was charged but out on bail for eighteen months, during which time he had visits with Joey and his older sister. The birth father was then convicted of second-degree murder. Although the aunt and uncle provided several times for the birth father to meet with the children to say good-bye, the birth father never chose to do this. The birth father died in jail

when Joey was 6 years old. There was considerable fighting in the family over the children—the grandparents on the birth father's side saying to the children how awful their mother had been and how much their father cared for them. The aunt and uncle went to court to gain supervision for these visits and then to limit the visits. The grandparents on the birth mother's (and aunt's) side carried on memorial rituals for the mother each year. At the time of the birth mother's murder, the older sister and the aunt had received therapy but Joey was 2 years old—the aunt and uncle were told, "He won't be affected by all that happened." This triggered the fury. The mental health system had failed him.

Assessment

I was given funding for two hours by the Ontario Criminal Injuries Compensation Board to prepare a report on how Joey was doing at this point. I considered writing a letter: "Experiencing trauma effects from incident at age 2, needs therapy," but resisted and scheduled a time to meet with Joey's parents and then with Joey for a short emotional assessment. A report would have to be written on my time.

I met first with Joey's now mom and dad.

> When a trauma has been validated, I meet first with the caregiver in order to be more sensitive, and hopefully more productive, in my session with the child. When a trauma has not been validated, I meet first with the child in order not to have any information that might bias me when looking at the drawings or listening to responses. In such a situation, I, obviously, would not have made the extensive initial phone call.

They were clearly caring people, but they were worn out and feeling hopeless. They described Joey as a kind and loving boy who would explode and go out of control. He would move very quickly from a "sunny" child to an angry child, to a spoiled little kid, and then settle down. He created constant havoc in the home, especially in the morning. In school, he only did what he absolutely had to do and would be set off by "absolutely nothing." Sometimes he would start swearing and hitting, and other times he would run away and hide. He was constantly concerned with disaster happening and had particular fears related to mom dying. He had been diagnosed with attention deficit/hyperactivity disorder (ADHD) and with oppositional defiant disorder (ODD), and placed on medication (Concerta and Ritalin). Joey had said to his mom and dad that he was crazy, and that he was afraid that he was born "bad" because he had his birth father's genes.

Mom then filled me in on the events prior to Joey's birth mother's death. There had been tension in the house. The birth father had asked for a divorce and the birth mother was insisting on certain terms. Mom said that Joey's birth father had, at the time of Joey's birth, denied that he was his father and had been very dismissive toward Joey. Only once during the two years had they heard the birth father make a positive comment toward Joey. Mom and Dad insisted that the children had been asleep at the time of the murder. They did say a lamp had fallen off the table during the strangulation. The children had been taken out of the house in the middle of the night. The birth father continued to insist, during the children's visits, that the birth mother's death was an accident although he was found guilty of second-degree murder. The visits continued until Joey was 6 years old at which time his birth father, still in jail, died.

At the end of the session with the parents, I told them how impressed I was with all the support and love they had given Joey over the years, and also congratulated them on bringing him to therapy. His behavior was not abnormal for a child who had had a traumatic loss and had experienced dismissive and frightening behavior from a parent. I talked with them about children using dissociation as a way of handling trauma and loss. I suggested they view the International Society for the Study of Trauma and Dissociation website, which included a section for parents comprising frequently asked questions (FAQs). I thought they would find the information helpful. I reassured them that dissociation and posttraumatic stress were not mental diseases but reactions to real-world situations, reactions that can settle with support from parents and work in therapy.

> It is important that parents leave the first session with something positive and a sense that things can get better. It is doubly important that parents know that posttraumatic stress disorder and dissociative disorders are not mental diseases (Kluft, 1984; Putnam, 1996; Silberg, 1996a). I tend not to use the term "disorder" but simply to describe the behaviors. Others, however, will use that term and parents need to be prepared to understand the meaning.

One week later I met with Joey. Joey was a tall, lanky, 10-year-old boy with curly hair. Although he had a tense and angry look, there was something very appealing and likable about him. He sat on the couch between his parents and tried to disappear into the cushions. His voice was that of a very young child. After some conversation, his parents left, and I asked Joey to draw a house.

Although drawings do not provide objective data regarding a child's functioning, they can provide a view of the child's experience of self and the world (Knoff, 2003). What children draw or say about their drawings comes from their experience. Given that both clinical and neuroscience research has indicated that dissociation consists principally of a dysfunction within the right pre-frontal/limbic areas (see Schore, 2013), nonverbal assessment procedures are particularly important when working with children with dissociation. I use the House, Tree, Person (HTP) Projective Test (Buck, 1948, 1970) as part of all child assessments.

If a child has a developmental delay or an eye–hand coordination problem, this would be important to take into consideration when viewing drawings. This was not the case for Joey.

Joey drew lines for the house, erased them, redrew them with a different pattern, turned the paper to do the edges of the door, erased the windows, and redrew them. He seemed unable to come to a stopping point, and when I did stop him, he told me he was not done (Figure 5.1).

In response to questions (questions were asked after all the pictures—not just individual pictures—were drawn), Joey said, "Where people live in and stones say welcome." "A family." "Dad and mom and two kids." I asked him to tell me about the family and Joey replied, "No thank you, grass, five windows, a door and a tulip growing out of grass." I asked about the frame around the house. "Sides, doesn't really show." With regard to the weather, Joey said, "It would be cloudy."

My stopping a child before he is through drawing a picture is very unusual. Stopping Joey was both a practical move—I needed to complete as much of the assessment as I could—and a therapeutic move—it felt like Joey was circling through and through the dilemma of what and, perhaps, who was family. I wanted him to feel there could be a way out.

The house drawing has been connected with a child's sense of family (Knoff, 2003). The erasures of the walls and windows could relate to having been in two families, the first one having dissolved. Turning the page to do the door brings up questions about who has gone in and out, which may or may not be related to the children being taken out of the home the night their mother was killed. The sides of the house being visible as a frame rather than in perspective raises questions but provides no clarity. The avoidance of talking about the family is to be expected for a child with a history such as Joey's. And, indeed, for him, the issue of family is cloudy.

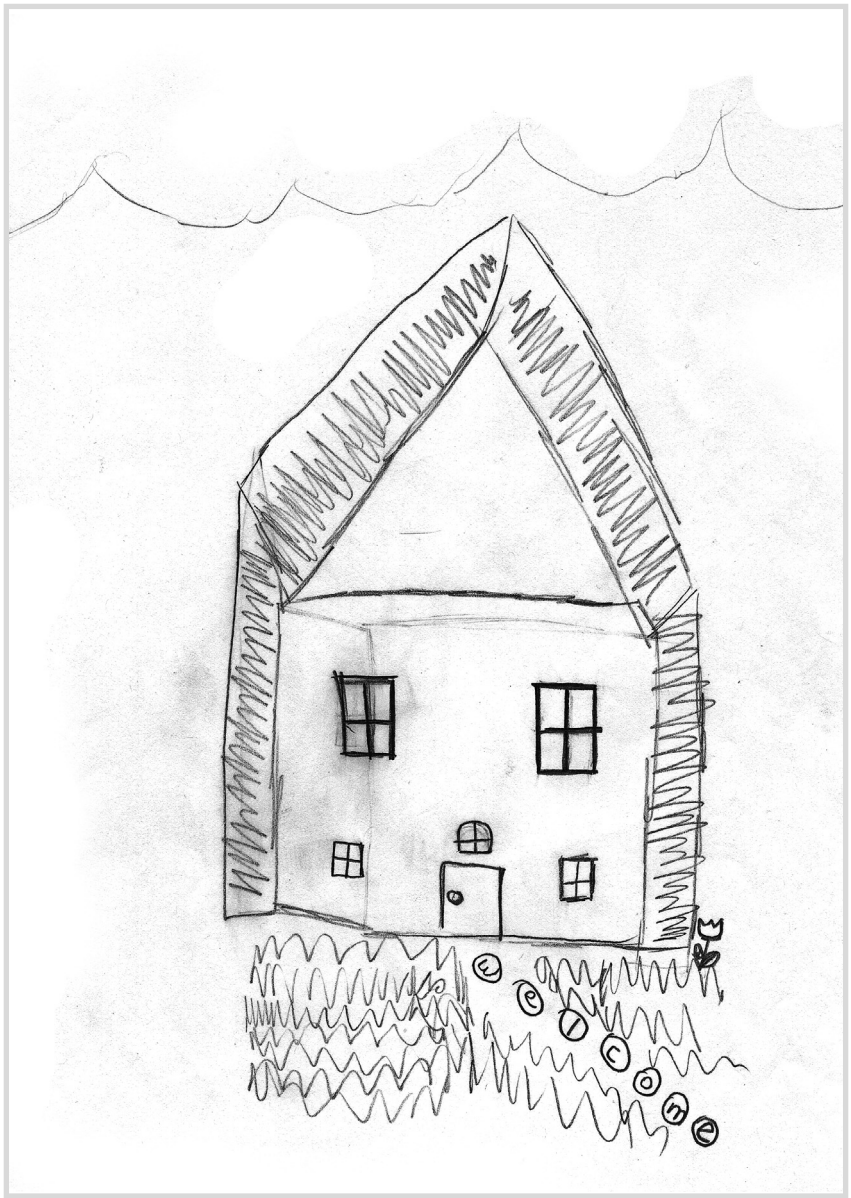


Figure 5.1 A house from the House, Tree, Person Projective Test. (Used with permission.)

For the tree, Joey started with the ground line, then the bottom of a trunk, did a top (deciduous), erased, placed dots for the top of the tree, filled in the lines between the dots, erased, said, "I'll only be a second," redid the top, erased, redid the trunk, and then did the outline for an evergreen tree and filled it in (Figure 5.2).

In response to questions, Joey said, "Evergreen tree." "Growing in or on a hill." "Healthy."



Figure 5.2 A tree from the House, Tree, Person Projective Test. (Used with permission.)

The tree drawing has been connected with a child's sense of self (Knoff, 2003). Joey's erasures could be connected with a sense of not being seen. While his use of dots, and later lines, to form trees that were then filled in is unusual, it is not clearly dissociative. This process made me think of Winnecott's false self (Winnecott, 1965). Changing from a deciduous tree to a coniferous tree did feel dissociative. Interesting that, despite all the difficulty he experienced drawing the tree, Joey was absolutely clear about it being healthy. This verbal response seemed definitely dissociated from the nonverbal drawing experience.

For the first person picture, Joey asked if he could do one of his doodle people. I asked for a real person (Figure 5.3).

After his first drawing, Joey asked if he could have a new piece of paper. I suggested he use the paper he had, and he flipped it over and drew a real face figure (Figure 5.4).

Joey noted, "He's bad, not one of my . . ." (not understandable and not repeated).

In reply to questions, Joey said, "He is looking at the ground and jumping." "Eleven years old." "Healthy and great." "Because he just feels like it."

The person picture may be connected with the way the child sees himself or herself, or connected with the way the child sees people of that particular gender (Knoff, 2003). It is always of interest what gender the child draws first. Because Joey gave his age for the person picture, it is likely connected to himself. Despite the request for a real person, the first drawing was of a robot. The anger on the face was clear. The large feet gave me the feeling of a toddler who stamps his feet. Deciding to draw a second person (an unusual event) certainly points toward dissociation. This figure was larger than the first and looked more scared than angry. Once again, the response to questions showed a very different developmental level and affect range than the drawings—an indicator of dissociation.

Joey's drawing in response to the request for a picture of a girl or woman was completed much more quickly and with fewer erasures (Figure 5.5).

Most striking were the multiple heavy lines for the legs. For the female person, Joey said, "Skating and happy." "Because she can skate." "Thirteen years old, no wait she is six." "Just learning."

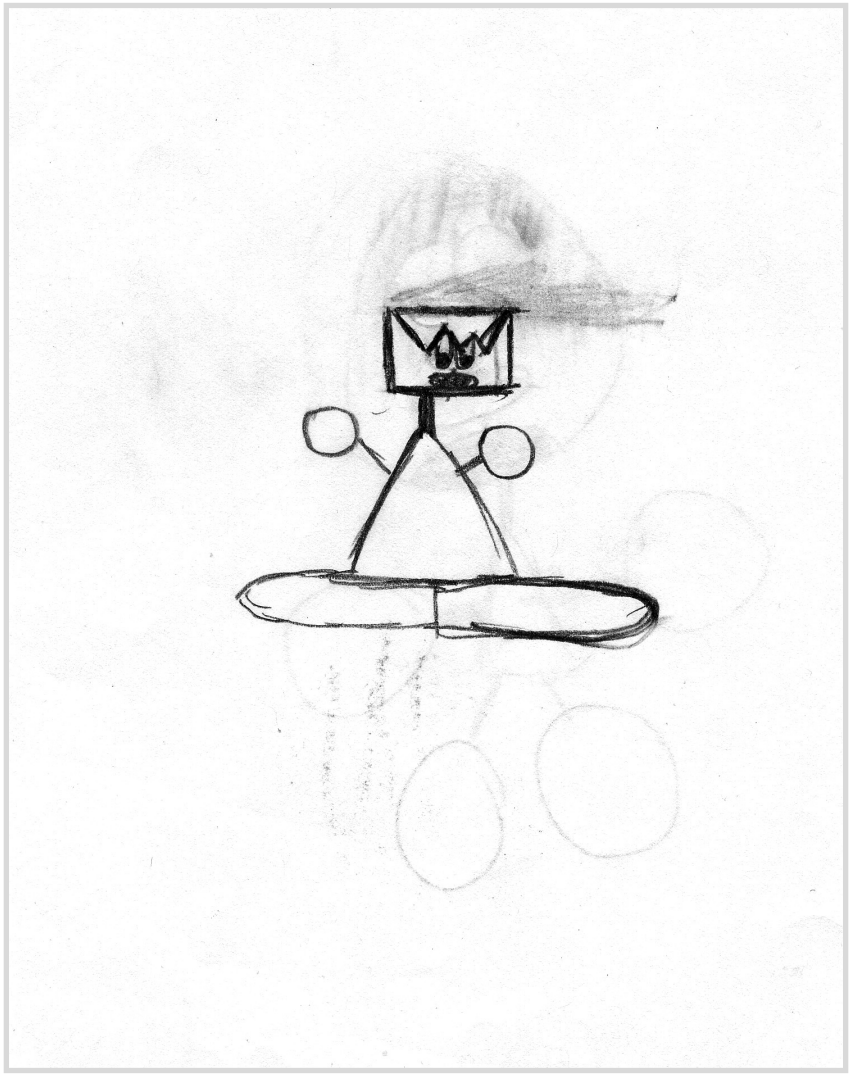


Figure 5.3 First drawing of a person from the House, Tree, Person Projective Test. (Used with permission.)

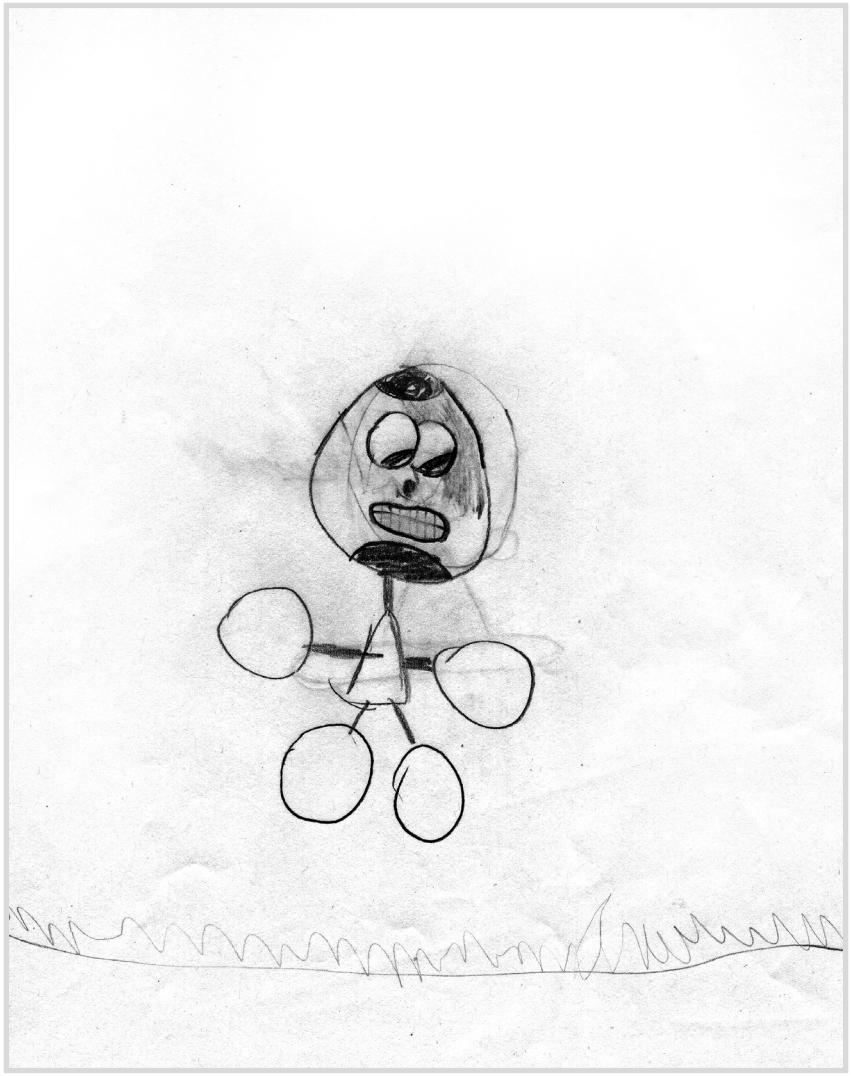


Figure 5.4 Second drawing of a person from the House, Tree, Person Projective Test. (Used with permission.)

A picture of a person of the opposite gender is not part of the formal HTP Projective Test. I, however, find it very helpful because the differences in the drawings of males and females are often very informative.

Although this picture included two erasures (right arm and mouth) and multiple lines in several areas with particularly heavy lines for the legs, the picture was far healthier than the picture of the male. Erasures and multiple lines indicate high anxiety. There was not a striking difference in ability to draw the picture and to tell about the picture. Clearly, Joey had had better experiences with females than males—this fit with his history. Perhaps the heavy multiple lines for the legs related to his wish his mother had gotten away—but this is just conjecture.

Because of the amount of time taken with the initial pictures, the additional assessment pictures (Family Kinetic Drawing, Why Are You Here Drawing) were not included.

Joey talked about liking to bike, having chicken burgers, and hanging out with friends. He named things he liked to do with his parents but could not name anything he did not like to do with them. Joey did say that school was "not going that well, I keep doing bad stuff, like getting in trouble, getting mad at others—not friends—other kids." He said he did not want to do those things, they just happened. He said he had a hard time paying attention in school. When asked where his mind went, Joey said, "like doing stuff." With regard to his noticing in school that he is working on math and everyone else has gone on to reading, he said it happened sometimes, but not often. With regard to time passing without him realizing, he acknowledged that happened quite a bit.

Moderate, but not extreme, dissociation was evident here. There appear to be gaps in awareness, as well as Joey engaging in behaviors he does not choose, but there does not appear to be amnesia.

I am always concerned when a child cannot name the things he does not like to do with his parents. This may indicate the child feels he has to artificially protect the relationship with the parents.

Joey was able to identify what sort of things made him happy or angry, or sad or scared.

With regard to what he does when he is angry, Joey described first yelling at others and then hurting himself by punching himself in the arm and, "if really mad," he would start to hit or swear at the other person. With regard to sad, Joey said he was sad if someone died and he would go to his parents or into his room. With regard to scared, he was scared his mother or father might die. His nightmares included people and himself dying. When asked



Figure 5.5 Picture of the opposite gender. (Used with permission.)

about things he was scared of when he was little, Joey said, "When Mom got killed." Joey then told me he was scared that his birth dad was going to kill him and his sister. He told me about all the phone calls that were made but, by the time the police got there, his birth mother was dead.

Joey named, "not going to a foster home, have a great family and getting stuff I wanted," as the three best things in his life, and "mom dying, a girl knowing I take pills, and cat dying" as the three worst things that have happened to him. He said he trusted his family and friends but did not trust people he did not know. He answered in the negative and showed no physical avoidance to all the questions about being touched or otherwise interfered with sexually.

Joey showed considerable clarity around feelings, around fear of parents dying, of being killed, and around what had been positive and negative in his life. His high fear around death was clearly a trauma response, but there was no indication of dissociation in this conversation. I was concerned about his behavior of hurting himself when angry—this often occurs with children who blame themselves for things going wrong, or as a way to calm down their arousal system and prevent themselves from hurting others.

When asked if he heard voices inside or outside his head, Joey said he "heard a big pop in my bedroom and a swish." When asked what he thought that was, Joey said, "Dad." He added that there were "sometimes voices in my head that say lie or steal something."

With regard to what he would be doing in ten years, Joey replied that he would be golfing, spending time with his family and, if he had a girlfriend, he would spend time biking with her. For three wishes, he said to get his video game back, get a car, and "If I could get my mom back." For his earliest memory, "I was two and my sister was five and my mom died."

Joey's response to questions about voices indicated dissociation and perhaps a flashback experience to the night his birth mother was killed. The negative content of the voices in his head highlights the dissociative quality of these voices (Silberg, 1996b). Joey's ability to project forward ten years with positive content indicated that his trauma experience, although very intrusive (see number of responses to death), had not totally overwhelmed him (Terr, 1990).

Joey showed clear awareness of the reality of his life. His attachment to his present family was difficult to evaluate because of the switches—based on the parents' report, the attachment appeared sometimes as secure, sometimes ambivalent, and sometimes avoidant. This is different from

disorganized attachment, in that there was no indication of fear (Liotti, 1999; Main and Hesse, 1990). Each attachment approach when it appeared was singularly there and not mixed together, as in disorganized attachment. Although Joey was clear he did not particularly want to be at my office, he was able to engage. There was an alert look in his eyes and I had liked him immediately. This interactive information, together with his comments about his family and friends, gave me the feeling that he had had some good attachment experiences in the early months of his life.

The Child Dissociative Checklist (CDC) (Peterson and Putnam, 1994; Putnam, 1997) completed by Mom was scored at 6, well within the normal range (#8, #9, #13, #16 being scored as present). On the Child Dissociative Experience Scale (CDES) (Stolbach, 1997), Joey scored at 15.5 for dissociation (below the threshold for dissociative symptoms) and 22 for posttraumatic stress disorder (PTSD) (above the threshold for posttrauma symptoms). This gave him a total score of 37.5, which was below the clinical cut-off score for PTSD (43).

The questionnaire scores did not indicate dissociation. The score of 12 is the clinical cut-off for dissociation on the CDC. I was surprised with the parents' low scoring of items, given the description they had given of his behavior, and decided to place more weight on their description.

For the CDES, the higher scoring for PTSD than dissociation highlighted that much of therapy would need to focus on trauma processing. Trauma processing is an important part of therapy for a child who dissociates. For Joey, it would be even more essential. Again, I was surprised that the responses for dissociative symptoms were so low. Was there a denial in this family of the seriousness of symptoms? Did Joey's positive phases overwrite the negative times for both his parents and himself? This might explain why the family had not sought out therapy for Joey sooner.

Joey's memory of his birth mother having died and of his fear of his birth father, his acknowledgement of both positive and negative feelings, as well as the low scoring on the questionnaires, indicated that he did not have a severe dissociative disorder. Yet, the report of his behaviors—yelling explosions, running and hiding, denial of negative behaviors, rapid switching to young child voice, rapid switching in and out of anger—indicated multiple symptoms of dissociation (see the Introduction, this volume). The patterns Joey showed in his drawings, the striking difference between clarity in verbal response and lack of clarity in drawing, his experiences of loss of time, and negative voices inside his head indicated dissociation at a moderate level. I arrived at a tentative diagnosis of dissociative disorder not elsewhere classified with a high level of trauma distress.

Assessment continues throughout a child's therapy. Silberg (2013) describes more detailed enquiries that can be used with the family and with the child either at the beginning of therapy, or as therapy moves along.

At the end of the assessment session with Joey, I mentioned that I could see there were many good things in his life, such as his now mom and dad and family and friends, but it also seemed as though there was a lot of sadness around his birth mother dying and also problems with the lying and stealing, and the voices inside that told him to do negative things. I told him that I worked with children who had had nasty things happen to them and ended up feeling really bad. My job, I said, was to help children with the bad memories and bad feelings that build up into problem behaviors such as stealing, and lying and fighting. I asked if he would like to get rid of some of the sadness and some of the behaviors that got him into so much trouble. Joey silently nodded. I said, "Great—so we have a plan." I added that it might be quite a while before we can meet again because we needed to arrange funding, but we would, and we would work on all of that then.

Here I was trying to establish some linkage with Joey and some goals for what we could do. To do an assessment and not give some information to the child at the end leaves the child hanging, and the therapist becomes one more person who asks questions and then nothing seems to happen. If funding were not so limited, this could have been done more carefully, with my asking Joey what he would like to change, rather than my doing the summation.

Beginning of Therapy

By the time the funding was established and an open time was found in my practice, two months had passed before I met with Joey again.

The gap in time (two months) between the assessment and the therapy was unfortunate and may have contributed to the length of the therapy. Whether funding became available or not, Joey clearly needed therapy. Some resource would have had to be found. My concern was that the therapy be carried out by someone cognizant not only of trauma, but also of dissociation and the therapeutic techniques needed to help a child integrate his or her dissociated parts. Unfortunately, not all therapists are trained in this area.

I met with Joey and his mom at the beginning of the first session.

I meet with the child and caregiver at the beginning of each session (adolescents can decide whether or not to have their parents in). This is a time during which attachment can be observed and worked on (shifted, or strengthened, or both—depending on what is needed), the parent's ability to be aware of the child and aware of what triggers the child can be observed and strengthened, and the child's actual safety and sense of safety can be evaluated and strengthened. Although an initial discussion related to establishing clearer and more consistent discipline in the home is better done with the parents alone, helping to fine-tune and bolster this discipline and the stability of the home can be done in little bits each week. We review what went well during the week and what did not go so well. With regard to the latter, we try to do some problem solving.

For Joey and his mom, there appeared already to be a secure attachment pattern. It was my hypothesis from this, and from that lively look in his eyes that I observed on first meeting with Joey, that he had had some very positive early nurturing. The secure attachment with his birth mother would have shifted to his aunt/his now mom. A secure attachment and a sense of safety are essential for a child with dissociation to achieve complete integration.

My other hypothesis was that the present world was not feeling safe enough for Joey. Not only was the early trauma not processed, but also Joey's parents did not seem to be aware of the situations that were triggering Joey. Based on the information I was given and Joey's assessment, I compiled quite a list of traumas: early rejection by the birth father, tension and arguing between birth parents, the events of the night of the murder (what they were specifically I was not sure, but the content Joey described experiencing in his head—a pop and a swish of his birth father in his room—together with his reported fear that his birth father would kill him and his sister certainly indicated strong memories of that night), movement between houses, loss of his birth mother, experiencing his grandmother's anger at his birth mother, visits with his birth father, and his birth father's death. This list undoubtedly would be added to as we went along.

With regard to safety, parents often assume that, if there is safety, the child will feel safe. If only it were that simple. Trauma creates a sense of danger—this tends to pervade the child's world, particularly in situations that are similar in some way to the trauma situations (triggers). For children who dissociate, there may be parts of the child that know about the present safety but also there are often parts of the child who do not know about the safety.

With regard to triggers, we would need to carefully observe the situations in which there was some switch in Joey's responding. What happened before the switch might help us identify the trauma event or situation that had been triggered. This would also help us identify what part of him that had been triggered (e.g., the very young part, the scared part, the part that did not feel safe, etc.). At first, we would try to control (and, if possible, eliminate) these triggers. As the trauma and dissociative work is done, the meaning Joey gives to these situations would shift. Then, trigger-type situations could be carefully reintroduced. We can never assume a child's world will not have triggers.

I explained why we had to wait so long to meet again. Mom told about Joey being suspended from school for taking a Nerf® gun to school and then "shooting" a girl in the eye. I tried to trace Joey's decision making in this incident to see if I could determine if this had to do with Joey not feeling safe (needed the gun at school). After some discussion, I asked Joey if he felt loved, to which he nodded. I then asked if he felt safe, and he shook his head. Mom was surprised and Joey reminded her of a shoving incident between his older brother and Dad. Mom tried to minimize what had happened, but I was able to highlight to her how fragile feelings of safety can be for children who have witnessed domestic violence. In response to my questions, Joey was able to say that his stomach felt tight, his arms weak, and his legs shaking when he thought about the shoving incident.

Therapy addressing either trauma or dissociation needs to include three phases—safety and stabilization, trauma processing, and integration/moving forward with life (Herman, 1992; van der Hart et al., 2006). As noted, it is important to start with the first step in therapy—safety. We need to be concerned not just with the reality of safety, which I was pretty sure Joey had, but also with the sense of safety. Joey's not feeling safe was important for Mom to hear directly from Joey. It was also important that I was there and could respond to Mom's minimizing of the events. Mom had been dismissing these incidents as part of having an adolescent son and not recognizing the larger impact on the other children in the family, especially Joey and his sister for whom violence in the family led to someone being killed. It was encouraging to learn that Joey had not dissociated body sensations (depersonalization). We would be able to use awareness of body sensations to help Joey integrate himself.

After Mom left, I showed Joey his box.

> I prepare a box of craft supplies for all children I see in therapy. Everything they make in therapy is kept in the box, as well as photos of their sand trays or other work they have done. It is important that paintings, and so forth, do not go home—imagine how it would be for a child seeing something that might represent trauma hanging on the fridge.

Joey asked if he could paint the box.

Very carefully, he divided the top of the box into sections. I commented on his design and how it reminded me of how each of us has many different parts to ourselves—a child part, a happy part, a sad part, an angry part, a thinking part—and how we needed all the parts together just as his box lid had all the sections together. Joey then filled in each section carefully with paint. He then wanted to paint a heart for his mom. I explained that we were out of time. Joey was an expert in coming up with how he could do this without taking much time and how important it was for him to do it. I was able to stay with what I said.

> Children sometimes paint their box during a middle phase of therapy or at the very end, but this was the first time I had a child paint the box in the first session. Was he telling me that it was really important he establish space in the therapy room (logical for a child who has had to move families), or was he telling me that he had an exterior self but not an interior self? I would need to wait and see. What was fascinating was the pattern Joey decided to paint on his box. Maybe he painted this just in case I had missed his dissociation during the assessment session. I always use any division created by a child to introduce the idea of parts and, most importantly, the idea of integration of parts.
>
> Boundaries, consistency, and predictability are so important for children who have been traumatized. Thus, it was very important that I stay with the time limit and not shift based on his Joey's wish. It could be argued that I was not hearing and validating him, but boundaries are important for a sense of safety, and that was the primary issue.

Explaining Dissociation

The following week, Mom started talking about how difficult the mornings were at their house. As she described Joey's behavior, I started a stick-figure diagram of the changes she saw (Figure 5.6).

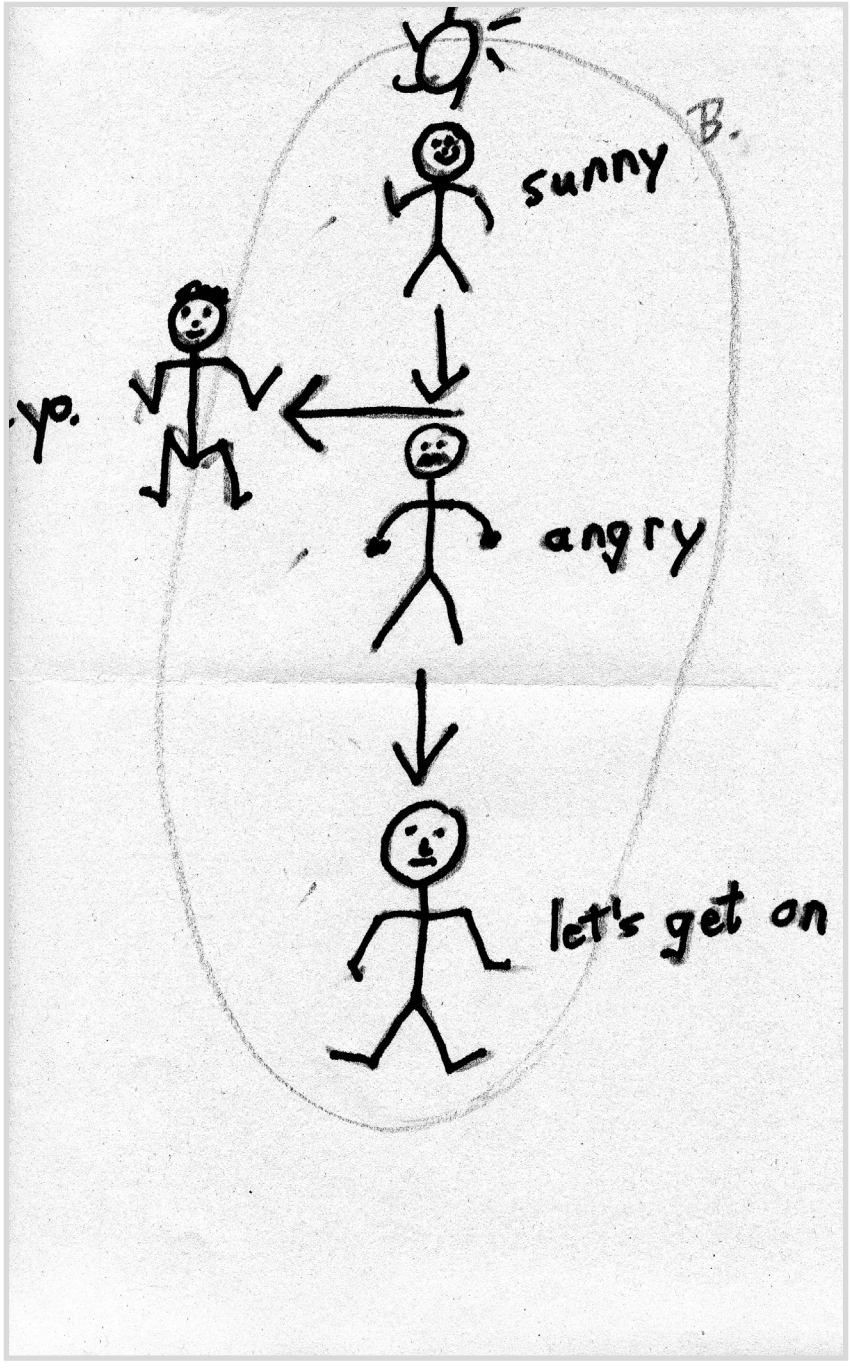


Figure 5.6 Diagram of Joey's changing behavior. (Used with permission.)

She talked about Joey being very sunny and then suddenly angry, and then, just as suddenly, ready to get on with things. As she described the behaviors, she talked about stamping and whining before the anger started, so I added the 2-year-old part. We talked about these being parts of Joey, and I wondered what was happening that triggered these changes. How could we make the time in the morning more predictable? This was going to be difficult, because Mom did shift work and sometimes was there and sometimes not. I encouraged Mom to find a way she could keep herself calm when Joey's behavior escalated.

During Joey's time, he painted a heart for his mom and then said it was no good. I asked if it was for his birth mom or this mom. He said it was for both of them. I asked how it made him feel. Joey said sad, and then talked about how everyone at school knew what had happened and he wished they did not.

This week I was able to start using parts language with Mom and Joey together. Using diagrams helps to make this process more concrete for both the child and the parent. Understanding the process helps the parent not react to each individual behavior.

Joey feeling that everyone at school knew about his mother's death meant that school was full of triggers for him. No wonder his behavior had been all over the place. This would have been a good time to establish contact with the classroom teacher. In that it was almost June, I did not make this contact. I should have, because it would have given me more information and might have been helpful for the teacher—if not for this child, then for children in the future. Therapists play an important role in educating the community about trauma and dissociation. Joey had been seen as a child with disorders (ADHD, ODD) and placed on medication. He was a child affected by trauma. Misdiagnosis following trauma happens all too often (Cole et al., 2005; Putnam, 1997; Waters, 2005).

I wondered if Joey not being sure each morning whether Mom was going to be there, or if she had already left for work, was possibly a trigger for the morning he was woken and his birth mother was not there. All of this needed to be looked at in considerably more detail. We needed to get some more stability and a sense of safety in Joey's world.

The conversation with Mom and Joey the next week highlighted several of the problems in the home. Joey had wanted a Pop-Tart® in the morning, to which Mom said, "No," but, at the end of the incident, gave to him. This allowed me to wonder what that taught Joey. Joey had been calling himself crazy. When I asked him where that came from, he said that Mom calls him "nut ball" and Dad calls him "crazy." Mom, predictably, said

this was said affectionately but was able to recognize how it might sound to Joey. The other issue that came up was Joey taking other people's gum.

During Joey's separate time, Joey looked in his box and said that there was nothing to do. I suggested we work on the problem of his taking other people's gum. I drew a stick figure that would be him and then asked if he had heard any voices before taking the gum (the voices reported during the assessment had been related to taking things) (Figure 5.7).

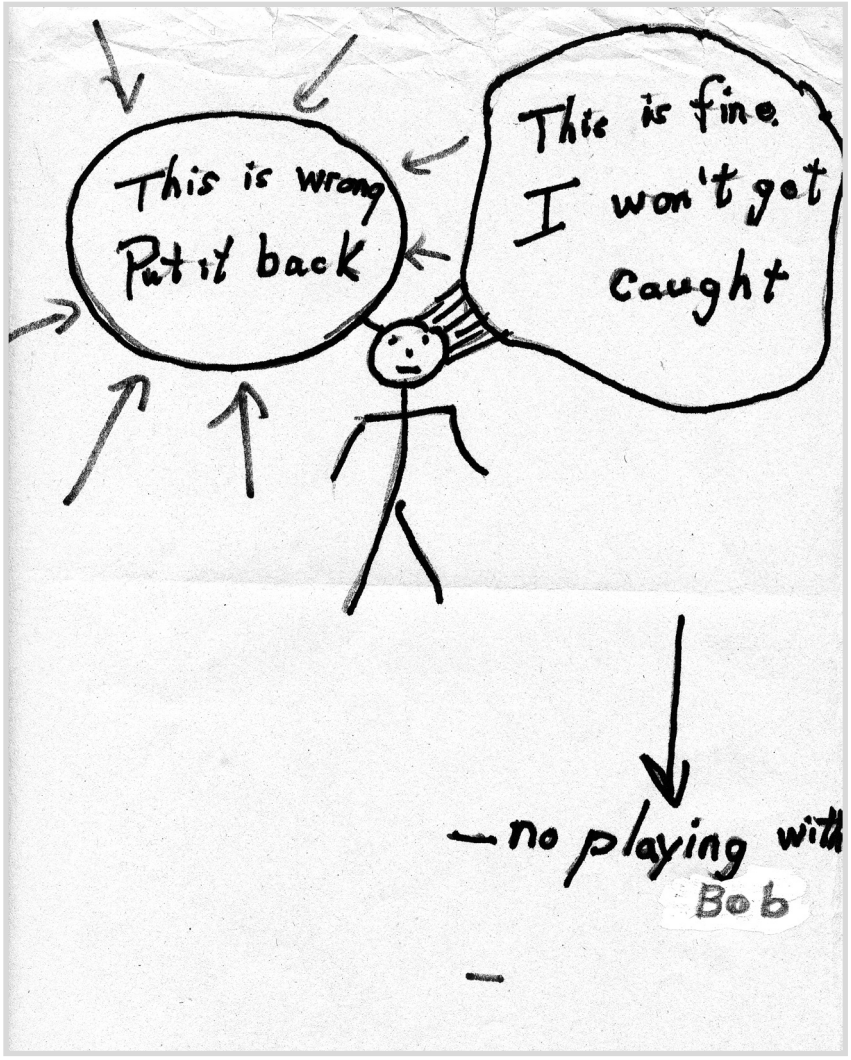


Figure 5.7 Joey and his voices. (Used with permission.)

Joey said, "This is wrong. Put it back." As I wrote that down in a thought bubble, I noted that he must have heard something else as well, or he would not have taken it. "This is fine, I won't get caught." I wrote this in a second bubble with multiple lines connecting it to Joey because it clearly was the stronger voice. I then asked what happened as a result of taking the gum. I put "no playing with Bob" (the consequence he received) at the bottom of the sheet. I commented that it sounded to me that it was not much fun being grounded from playing with his friend, and asked was there a way to avoid that? Joey said he did not know. I asked what would have happened if he had listened to the voice that said it was wrong, and he was able to respond to that.

The value of working with both parent and child was highlighted in this session. Joey's parents very much wanted to do the right thing for him but were clearly oblivious to the effect of their comments on him. Mother's inconsistent responding to negative behavior was, of course, a reinforcer. Joey would keep pushing the next time Mom said "no" to something, because, after all, she might just give in.

With Joey, I wanted him to become more aware of the parts inside. Only when the individual has become aware of the parts, can the parts start to work together (Putnam, 1997; Silberg, 2013; Wieland, 1998).

At the next session, Mom talked about Joey calling her mean (he did not remember this) and his flinching when she came close to him quickly. I wondered if he was remembering the past when his birth dad had hit him. Joey hid his face in the pillows.

I talked about all of us having different feelings inside. As I talked, I drew a pie with some of the feelings Joey would have had as a little boy (Figure 5.8).

I explained that when a child becomes too scared, as Joey would have when his birth father made fun of him and when his birth father killed his birth mother, the child cannot hold all that scariness inside. A child will push the scared feeling away from the rest of himself because, if he does not, it feels as though the scared part will take over the whole of him and he (Joey) will not be there anymore. (I was drawing the scared part farther and farther away as I talked.) I then explained that when the scared part is way out here (pointing to the part farthest away), it does not know that Joey's world is now a safe one. That part of Joey may still be feeling the world is scary, as it was when he was 2 years old. Joey peeked out from the pillows and watched what I was drawing. I also talked about a child getting angry and pulling that part away because it felt so bad—it does not feel safe to be angry at a parent-figure. And there would have been the playful part and also the sad part from when his birth mother died.

Joey said he was scared he was similar to his birth father. I asked Mom how Joey was different from his birth father, and mom mentioned how kind Joey was and how selfish his birth dad was. With this, I decided to do a new pie diagram looking at Joey now. The first pie was labeled "2 years."

We started the new pie by listing the feelings and activities that Joey had now (Figure 5.9).

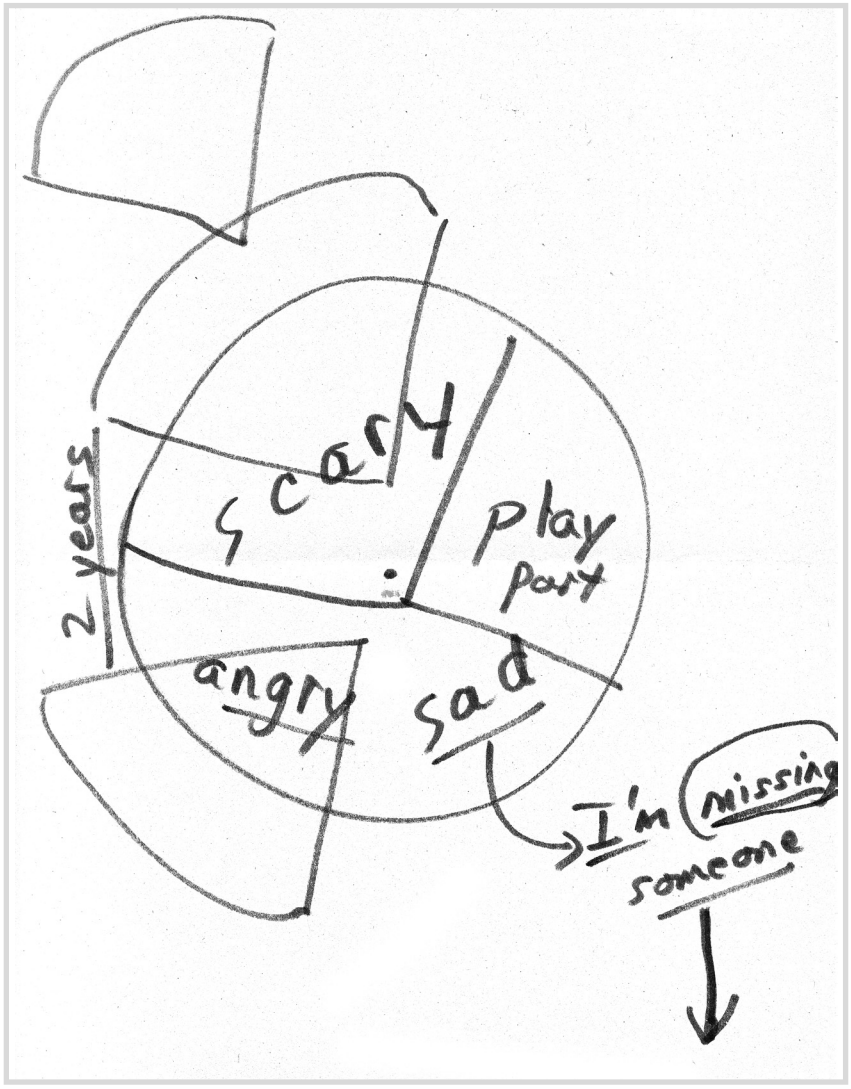


Figure 5.8 Pie diagram of Joey as a 2-year-old. (Used with permission.)

He then showed me how much of the pie each feeling or activity would take. I placed the "thinking Joey" in the very middle and asked him to place the part of him that thought he was similar to his birth dad. He first put it in the scared section and then drew an arrow over to the angry section. I then asked about the part that sometimes thought he was crazy, and he said, "Both scared and angry," and I drew that in.

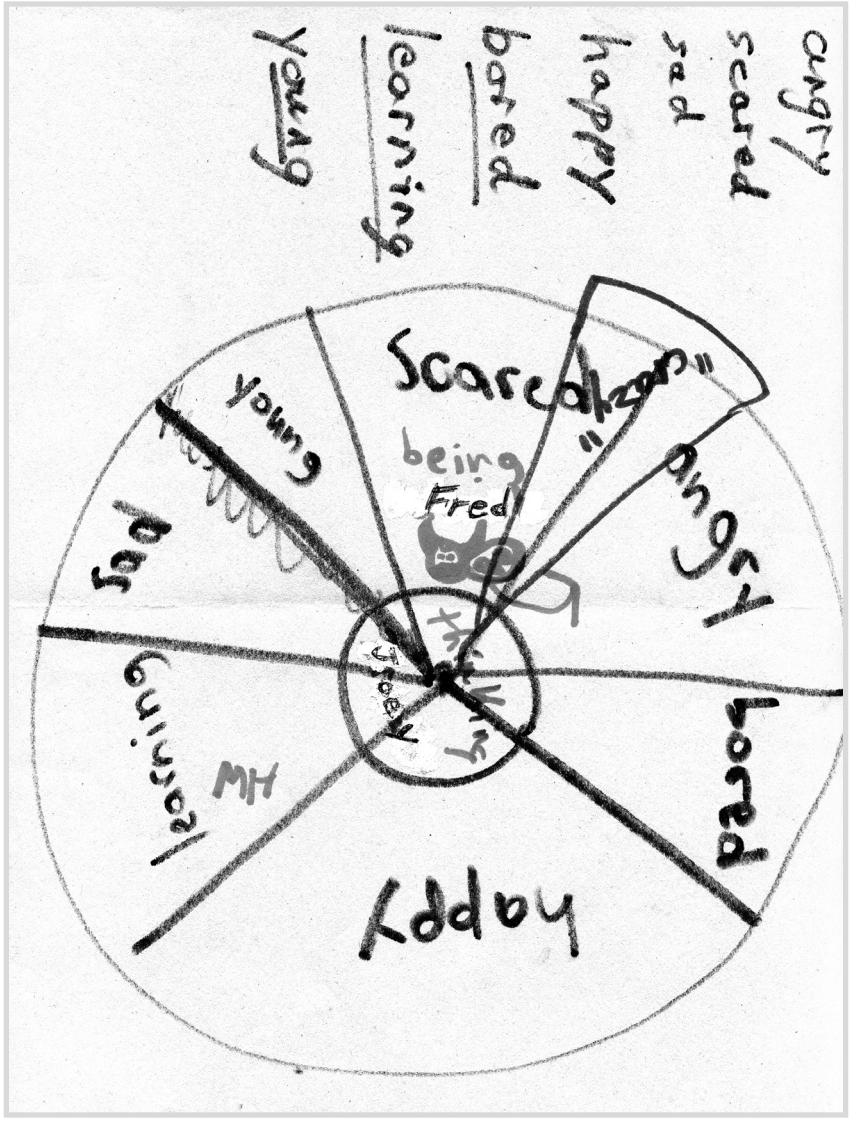


Figure 5.9 Pie diagram of Joey now. (Used with permission.)

I suggested to Mom that when Joey seemed to go into the angry part, or the scared part, or the young part, she should say his name, tell him where he is, and tell him he is safe and that he is not going to be hurt.

Here I was trying to educate both Joey and his mom about dissociation—when it happens, why it happens, and how (in lay terminology) it happens. Although Joyanna Silberg (2013) had not, at that time, presented her Affect Avoidance Theory of dissociation, my explanation of dissociation certainly reflects this theory. The feelings that had come up during the early relationship trauma with his father, at the time of the trauma of his mother's murder and his move to another family, and his grief that was ignored were so overwhelming that they had to be avoided. Behaviors such as yelling, misbehaving, and lying enabled Joey to avoid feeling his fear, anger and grief.

As Silberg (2013) highlights in the acronym EDUCATE for her treatment model, education about dissociation is an essential part of a treatment plan for a child with dissociation. The pie diagram is based on the ego-state model of dissociation (Watkins and Watkins, 1979, 1993). In particular, I wanted Mom to understand that, with the dissociation, there was very likely a part of Joey that did not know he was safe now. This would need to be reviewed many times and with many different examples during therapy. Suggestions for grounding (the A in Silberg's acronym: arousal modulation) would also need to be given several times. It is so tempting to avoid naming the crazy feeling, because one does not want to reinforce the feeling. I always have to remind myself—name what is hard and then it is easier.

The suggestions to Mom related to grounding were based on the information provided in the FAQs for parents and teachers (ISSTD, 2008, 2009 provided at: www.isst-d.org/default.asp?contentID=100 and www.isst-d.org/default.asp?contentID=101).

Dad came with Joey for the next appointment. Joey was subdued as usual but seemed more like an 11-year-old than when he was with Mom. Dad reported on an incident at school and brought me a letter from the principal. Pencils had been taken from another classroom and then, when Joey started giving extra pencils to his friends, the teacher asked him where they had come from. Joey said he had brought them from home. When the teacher suggested he had taken them from the other class, Joey started swearing and pushing. He then ran out of the class. When he was found and taken to the office, Joey told the principal he wanted to die.

I noted that it seemed that when the teacher talked to him about taking the pencils, it was an explosive part that came out (swearing and pushing), then a scared part (running away), and then a hopeless part (wanting to

die). When I asked about voices inside, Joey said they told him not to tell about the pencils, to lie. I wondered what had led to the taking of the pencils. Dad replied that he did not see Joey's behavior as being triggered by something, that his taking of things was intricately planned and, thus, not sudden. I noted that this did seem confusing, especially when there were the other times when Joey could behave so well. I wondered if the thinking part of Joey that could be very helpful with good behavior also "helped" when he felt he was missing something. I suggested to Dad that Mom and Dad comment and compliment Joey when they notice the thinking part of him doing something positive. Joey then told me he had hit his sister last week, and then said he was sorry and had tried not to do it again. I told him I was really impressed with the thinking part of him and how it had worked with the part of him that was angry at his sister.

During Joey's time, when he was wandering around the room, I asked if he would make me a sand tray of what it was like with voices inside. Joey took out some trucks and cars and had the trucks banging up against the cars. First, the cars were buried, and then the trucks that had hit the cars were buried. He then repeated the same theme with people—people getting hurt and buried, and then the people who did the hurting were buried. The only object left on top of the sand was one piece of fencing. I noted that there seemed to be a lot of fighting and a lot of burying; I wondered if that was what it felt like inside—fighting and burying. Joey took a photo of the sand tray. The photo was half-shaded, something that seldom happens.

I experienced Dad as less receptive to the idea of dissociation than Mom and more concerned with the negative aspect of Joey's behavior. I wondered how Joey experienced Dad. In the session, I wanted to focus more on Joey's ability to do things well than on the problem behavior. His positive abilities were going to be important in helping him make sense of his experiences and in helping him pull all the parts of him together. At the same time, I also wanted to listen to Dad's concerns. Therapy is always a balance between many themes.

Thinking back on the session, I realized I should have explained what I meant by "helped when [Joey] felt he was missing something." I was working from the hypothesis that Joey taking things (often things of very little value and, most frequently, from his sister) was his unconscious effort to try to fill the missing feeling from the loss of birth mother.

Joey's response to my question regarding voices raised a concern. Children can learn very quickly to blame the voices inside, rather than to accept responsibility for what they have done. I should have noted at that point that he was responsible for everything he did—when he did what the thinking part of him told him, when he did what the voices told him, when he did what the scared part of him felt like doing. I would need to remember

this in the future—there are so many different threads to be followed when dealing with dissociation.

Watching Joey's use of the figures in the sand tray, it seemed as though he was telling me about the battle between parts of himself. Unfortunately, my understanding was shaped by my initial question. Looking back at the content, Joey may have been "telling" me about his birth father killing his birth mother (hurting and burying) and then his birth father dying (burying). I needed to be more alert and more open. Fortunately, one of the things we know about children's play is that if we do not understand it the first time, they "tell" us again.

Both parents came with Joey for the next appointment. Together with a friend, Joey had taken two new scooters from the school yard, had switched parts on the scooters so they could not be recognized, and then started using them. When asked about the scooters, Joey had lied vociferously. In the session, Joey alternated between crying and demanding. His reactions were not to the event but to the consequences imposed by his parents. His parents described how Joey would become extremely angry when given a consequence and would blame them for being unfair, for ruining his life. Joey said he had lied because he was afraid the police would be called. Last fall, the parents had called the police following a stealing incident and had them come to the house to talk with Joey. Joey had been quite scared. For the present incident, they had decided Joey would have to take the scooters back to the owners—the embarrassment of this was the consequence for stealing. The consequence for the lying was being grounded. That the grounding was happening over a weekend was what made Joey so angry.

I scheduled the session the following week for just Mom and Dad, and apologized to Joey for taking up the entire session with him and his parents.

Dad spoke to me after the session. Although the parents had insisted to me at the beginning that there had not been frightening events before the night of the murder, they had started to remember some events. When Joey was aged under 2 years and playing with something, birth dad told him not to. When Joey did not stop, birth dad hit Joey so hard he fell off the couch. This had happened on a visit at the grandparents' house—similar things must have happened at home. Dad and Mom also remembered birth mother talking about times when she was hit by the birth father when the children were around.

I clearly had not listened carefully enough to Dad's comment about intricate planning. Joey's taking and disguising of the scooters certainly highlighted his thinking through of how to get away with something. In this session, I

was struck with the parents' efforts to have Joey understand why he was being given the consequence. They needed to learn to stay out of debates with Joey. It also seemed to me that the choice of consequence had been *ad hoc*—Joey had not known what to expect.

Understandably, the police talking with Joey had been scary. His other contact with them was in relation to his birth father's murder of his birth mother and his father going to jail. Was this one of the reasons he thought he was similar to his birth father?

Not saving at least some time at the end of the session for Joey alone was a mistake. I needed to be more consistent and predictable in my way of doing things.

Working With Parents

During the session with just Mom and Dad, we talked about the challenge of parenting a child such as Joey. Not only was his behavior hard to understand—why he got involved in these negative behaviors when their other three (two birth and Joey's older sister) children did not, but also why he did not react to their consequences in the same way the others had. I noted that he was dealing with more unresolved trauma than the others, and negative behavior is often the way the child avoids the huge negative affect from the trauma, as well as being a way to let adults know he is hurting inside. For the child who has been traumatized, safety and predictability are *very* important. There had been no safety and no predictability in his world when he was young. I also explained that when a child dissociates, the part of him that engages in negative behaviors may be quite separate from the part of him that has to serve the consequences—thus, learning from consequences is difficult.

We listed the behaviors Mom and Dad found most difficult and then established priority. For each one, we determined a specific consequence. We established two levels of consequences for several of the behaviors—one level if Joey was able to switch his awareness to recognition of what he had done, and a second level if Joey remained in the denial or amnesic (I was not sure which it was) mode. Where possible, we used logical consequences.

I encouraged Mom and Dad to start with just the first two or three behaviors. For this to be helpful to Joey and to them, they would have to be absolutely consistent. I stressed how hard it is for parents to be completely consistent when working on too many different problem behaviors. Once the first two or three behaviors were under control, then they could move on to include some of the others. I also encouraged them to sit down with Joey and explain the new system of consequences. This would help to make his world more predictable.

Because "lying" had been such a persistent problem, I noted that a full day without lying might be too long a time period for Joey to achieve—success is a very important part of a behavior chart. They might consider breaking the day into three or more parts. Each part-day without "lying" would bring extra individual time with a parent and each part-day with "lying" would mean losing playtime during that part of the day with friends or siblings.

I should have scheduled this session without Joey earlier in the therapy. Creating stability for the child is the second step in therapy after safety. Predictable and consistent consequences are a crucial part of stability (Wieland, 2007). And, in turn, they help the child behave better, which in itself creates stability. Parents become more confident and less reactive, which leads to even more stability.

Children need rewards (individual time with parents is an excellent reward), as well as consequences. When behavior is really difficult, it is important to divide the day into parts with a possible reward for a positive hour or couple of hours. The child experiencing success is crucial to shifting behavior.

At the end of that session, I talked about the plan for therapy—we had started with safety, we were now working on creating more stability in Joey's life and on helping him understand the dissociation he was experiencing. When Joey seemed more stable and more secure, we would then meet all together to make a timeline of his life. This would need to include positive things as well as negative things. I noted how important it would be to have the early rejection he experienced from his birth father, as well as the tension between his birth mother and birth father, on the timeline, in addition to the more obvious events such as his birth mother's death. I let them know that parents find this session very difficult because the natural desire of parents is to not cause distress for their child. I have found that it really helps for the parents to write it out and for me to go over it with them. I asked Mom and Dad to do that and send it to me.

The parents filled me in on some more of the dynamics Joey would have experienced. Particularly distressing to the children had been their birth father's insistence that their birth mother's death had been an accident. During the visits with their birth father before he went to jail, the children often misbehaved. The supervisor would urge him to discipline them, but he refused saying that was not his job. The other behavior that the parents reported was that on each visit, the birth father would put his body cologne on Joey and their birth mother's perfume on his sister.

Further Explanation of Dissociation

Joey had to be taken out of school for the next appointment and was missing a special event.

His behavior was understandably resistant and negative. Mom said she knew he was disappointed but asked him to behave better, and Joey said he was just retarded—after all, that was why he was coming here. Mom noted how smart he was, not retarded. I noted how his needing to come for therapy was not a result of him—he was clearly a smart, capable boy—but of things that had happened around him when he was little, things that had been both scary and confusing—fighting between his birth parents, his birth dad killing his birth mom, having to move families, and his birth dad dying.

I reviewed what happens when scary things happen. This time I used my doll that has four little dolls inside (one with a scared expression, one with an angry expression, one with a sad expression, and one with a happy expression) (Figure 5.10).

I talked about children wanting to keep the scared, angry, sad feelings away because the feelings do not feel safe (taking the appropriate doll out as I talked about a particular aspect of Joey's life), and also wanting to keep the happy feelings separate so they would not be spoiled by all the other feelings. I said it made sense that he had many different ways of feeling, of being—this was not being retarded; in fact, it was very smart because it helped him cope with a confusing world. I explained that we call it "dissociation" because the different parts had moved apart—



Figure 5.10 Dissociative doll. (Used with permission.)

dissociated from each other. Our job was to understand better what had happened, to understand better each of the feelings/each of the parts, to understand how important each part had been, and to help all the parts now work together—associate.

During Joey's time, he painted one side of his box green, another black, and another brown. I commented that the feeling chart on the wall of the office had green for scared and black for discouraged. I wondered what the brown was for. Joey did not know. I wondered if it was for disappointed, which was the way he had been feeling when he came in. Joey did not respond but started talking about playing golf and how much he enjoyed golf.

My preference is always for a consistent time and day for therapy (another aspect of stability in a child's life). With Mom working shift work and Dad working long hours, this was not possible, and one works with the possible. The timing of this particular appointment was unfortunate because Joey missed a special event at school. It did, however, elicit Joey's understanding of why he was coming to therapy. This had not been discussed specifically since the assessment session four months earlier—another error on my part. As a therapist, one has to be careful not to spend too much energy on errors. If one does, one can get caught in the discouragement that so often consumes the people with whom we work. Rather, we need to note the errors and learn from them—what we want the people we work with to do.

I find the dissociation doll very helpful when explaining dissociation to both children and adults. Sometimes, I create the story with general happenings and, sometimes, I do it with a specific story, as I did with Joey. Many children have not been talked to about the early traumas. It can be helpful for the children to understand that there are reasons (see Affect Avoidance Theory; Silberg, 2013) for the fragmented way they are feeling inside.

Although Joey did not acknowledge the disappointment, I felt his being able to switch from the talk about negative feelings to something positive for him was an indication that something was relieved. The other interpretation of the switch would be that he had dissociated but that was not the feeling I had.

As therapists, we must always remember how much more time children spend in their home and school environments, and how much more important those environments are to them than therapy (Silberg, 2013). Thus, we need always to be working with the parents and teachers to improve those environments. I had already become aware that, even though Joey's home was very well-meaning, hurtful casual comments were often made. I needed Mom to be more aware of this.

At the end of the session, I asked Mom to comment at home when she noticed Joey thinking clearly, being smart. Also, I asked her to notice comments Joey's siblings might be making unthinkingly that could reinforce his feeling of being not capable or being retarded.

Everything is Not Dissociation

At the next session, it felt as though things were getting worse. Joey was curled up in a corner of the couch. Mom explained that over the weekend she and Dad had gone out in the evening and the older siblings had been in charge. Joey had been told he was not to go out but he did. As a result, he had been grounded from going to the waterslides with friends but was told he could go to the school end-of-the-year party. When Joey started yelling this morning before school, Dad threatened he would take away the school party—Joey kept right on yelling and lost the chance to go to the party. When I asked Joey about this, he said that he thought Dad would give him three chances. Mom was startled when Joey said this but clearly made note of it. Mom confirmed that Dad had a very hard time disciplining Joey and still sometimes gave in.

Joey spent the time when Mom was in the room curled up in the corner of the couch and, during his own time, continued in the corner. I asked him if there was anything he wanted to do. When there was no reply, I noted that it seemed as if the part of Joey who wished his world was different was here. I wondered if that was part of the sad part of him, or a separate part. Other than that, I sat quietly.

At the beginning of the session, I felt quite discouraged and could certainly feel Mom's discouragement. During this session, I felt we were not dealing with dissociation but, rather, with a smart, poorly disciplined child. Perhaps the behavior at the end was also not dissociative but a normal sulking child. Joey had been "running" the home for several years and it would take several discipline experiences for him to shift his behavior.

In contrast to the children with dissociative identity disorder, children with dissociative disorder not elsewhere classified (American Psychiatric Association, 2013) may experience considerable shifting in the parts or aspects of self. How Joey was presenting curled up on the couch did not seem to fit with one particular affect or emotion but, rather, with some combination of grief and discouragement. With the name I gave the part, I was trying to attune to what was going on inside Joey (Hughes, 2009). Attunement provides a child with an experience of being "heard," an experience that many traumatized children lack.

The next week brought multiple discipline experiences—in fact, so many it was going to be days before Joey was going to be able to play with anyone again. I suggested that all consequences end at the end of a day and then Joey start with a clean slate the next day.

Joey kept telling Mom he was going to stop yelling, and lying, and sneaking behind their backs. Mom said that just felt like one more lie. He had said it before and not done it, why should she believe him now? Joey said that he could not stop himself from lying—it would just happen, even when he did not want it to. He said, "I'm bad like Fred [birth dad]." I asked if lying was something his birth dad had taught him and then asked what he could teach himself.

During his time, Joey decided to paint on the paper towels rather than the paper that was available. He then wanted to take them down to the washroom and put them under the faucet. Most of the color washed out leaving a very faint tie-dye effect. I commented that just like he could choose to get rid of colors he did not want, he could choose to get rid of habits he did not want, and asked if lying was a habit he wanted to wash out. Joey did not respond but wanted to show his finished product to Mom.

> The most important part of consequences is when they end and the child has a chance to do something different, something more positive (Dreikurs and Cassell, 1990). That is the time when positive behavior can be learned. The way things were going for Joey, he was not going to have enough time to learn. I tried to do some fine-tuning around consequences with Mom—this was going to need to be an ongoing job.
>
> Once again, I was in a quandary—what was dissociative (maybe the part of him that wanted so much to behave really believed he would stop yelling and lying) and what was learned (maybe this time they will let me off)? Given Joey's comment, it may have been the part of Joey that he had internalized from his birth father—a product of mirror neurons (Howell, 2011). Mom and Dad had both described the birth father as a glib liar. I suspected that it was a bit of all three.

Joey and his mom returned after two weeks of camping. Joey announced right at the beginning of the session that he had not stolen anything over the last two weeks. We spent quite a bit of time talking about this and about the excellent skim boarding he had done during the holiday. Mom was really pleased with Joey's behavior during this time. Joey brought up the fact that he had dived into a pool where he had been told not to but, when asked about it, had told the truth.

Mom did tell about Joey becoming "obsessed" with a girl in the next campsite. Joey was very embarrassed during this conversation. Evidently after meeting her once, Joey had gone up to the girl and asked her if she

liked him, told her he loved her, and started following her around. When he was told not to do that, he stood behind a tree for extended periods of time watching her. Mom had noticed that whenever the girl was around, Joey's walk seemed to shift to a swagger similar to the walk of an 18-year-old. She asked to speak to me alone and, when Joey left, said what scared her was that Joey's birth father used to stalk women and had been known to abuse adolescent girls. She wondered if this type of behavior was in Joey's genes—it reminded her of the time Joey had become obsessed with a girl at school and kept writing her notes, and following her even when told not to do so. Mom reminded me again that when the children visited the birth father before he went to jail, he would put his cologne on Joey and birth mother's perfume on his sister. They would come back smelling heavily of these scents.

I told Mom I did not know what would have caused the obsessive-type behavior with the girl but I would think about it. Mom said they had an appointment with the psychiatrist the end of the week and she would be talking to him. I asked for her permission to write to the psychiatrist with any thoughts I had.

Joey came back in for his time. In the wet sand, he built castles. He talked about having told the truth about diving into the pool. I affirmed that he had taught himself a new habit. He then switched to the dry sand and had two sides fighting. The bad characters were doing mean things to the other characters. There was no resolution to this even when I warned Joey that we were going to need to stop soon. I commented on what the characters were doing but did not give an interpretation.

Finally, things seemed to be getting better. But what was this obsessive behavior about? Other obsessive patterns had not been reported. Was it a dissociated part? Where had it come from? I wondered what the birth father had told Joey and his sister when putting cologne and perfume on them. I must admit my thoughts toward the birth father were extremely negative and I supposed the worst.

I found it interesting that he started out playing with the wet sand—the first time he had used it. Playing with wet sand is toddler-type behavior and is often done when a child is in a regressed state. As he talked about his not having lied, I had the sense of the younger him who was mischievous but wanted to do things right and was proud of not lying. I might have used more dissociative language, noting that the part of him who wanted to be honest had been in charge, and this probably would have been a better reply. I had been following up on our previous conversation. Then, the switch to the dry sand—was that the older part of him who had become involved in doing mean things? I noticed what Joey had done because I felt he may not have received enough mirroring/noticing over the years. At the age of

2 years, he and his sister came into a family where there were already two children. His new mom and dad became involved with a legal fight for the children to remain with them and for supervision during the visits with the birth father or paternal grandparents. There would not have been much time or energy left. Even though I hypothesized as to what his play might mean (the parts fighting inside), I did not feel certain enough to say anything.

And I had no clear sense of what the behavior toward the girl meant. What I did feel clear about was not wanting the psychiatrist to increase Joey's medication. Medication can, at times, be helpful for children who dissociate (Graham, 1996) and certainly, according to the mother, had been very helpful for Joey in the past, but I did not want negative behaviors suppressed. We needed them there to work with. I also was hoping to create some form of collaboration with the psychiatrist. Given that our medical system provides ongoing funding for psychiatrists and not psychologists, the psychiatrist was more likely to have long-term contact with this family than I was.

I sought consultation from my colleagues at the Center for Treatment of Sexual Abuse and Childhood Trauma. Consultation is so important, particularly when working with children such as Joey who have experienced complex trauma—the loss of his birth mother was only one piece of his experience. It seemed to us that this was some form of behavior learned from his birth father. It might belong to a dissociated part of Joey, which would explain why it had not been tempered by observing his present mom and dad's behavior. We also discussed mom's fear that there could be an inherited pattern of responding with females. This was something we did not know enough about either to accept or to reject. Because of the difficulty of making phone contact, I wrote and faxed a letter to the psychiatrist. I described my work with Joey and the present behavioral concerns. I noted the two explanations that we had arrived at and asked for his thoughts. I received a phone message back noting that he was leaving on holidays. He felt Joey was responding to increased anxiety. My question remained—why responding in this manner? What had been triggered for him when he saw the girl at the campsite?

The next week, mom reported that Joey was doing very well. They had set up guidelines around calling for permission to do things, rather than assuming permission or pressuring siblings. Joey was checking out every possible loophole, but Mom was very consistent. I was able to give her a great deal of praise for her consistency. The tension in the home seemed to have decreased.

During Joey's separate time, he went to the dry sand tray. The human figures he took out were all buried. There was considerable confusion to

the play, and I was not able to discern any pattern. I noted the confusion and wondered if it was like that in his family now. Joey said, "No." I then linked the confusion to his early home. Joey took the gravestone out of the cupboard and placed it inside the fencing. I commented on all the early confusion and then his birth mother dying. I said I thought we should start looking at some of the early things that had happened. Joey froze a bit when I said that but did take a picture of the sand tray to add to his things in his box.

> It really felt as if stability was finally happening. One might wonder at the play pattern, given that things were going better in the present family. Joey seemed to be way ahead of me, letting me know what needed to be done next. But, given his response to my comment about looking at early events, I may have moved too quickly.

Mom was not able to come to the next session. Dad told about Joey taking candy that morning before breakfast. His eating sweets before breakfast had improved, but then this morning was really bad. I suggested they make a plan in the evening as to what he could eat before the rest of the family was up and set it out for him. Dad was quite negative with regard to these ideas. Joey stated that he was behaving poorly because there were too many consequences. Dad talked about Joey having two motors in his brain. One was well-oiled, and knew that lying and stealing was not okay. The other motor was rusty, and was stuck with the lying and stealing. He said consequences were like oil to the rusty motor. Dad then commented that other than mornings, Joey was doing well. He felt the problem was that Joey's medications from the day before had been used up and he had not yet had his new dose. I wondered if mornings were bad because that was the time when the children were told their mother was dead. Dad was clearly skeptical but did not say much.

During Joey's time, I recalled that I had talked with him about our starting to talk about some of the early events today, but that I wanted both mom and dad here for doing that. Joey was very creative with the plasticine and the pipe cleaners in his box. I noted how smart he was. He told me I should have LEGO®s. Then, he could make a sad man and a mad man to show me. I asked him what he did to help calm the sad man part and the mad man part. Joey said sometimes he played with LEGO®s, sometimes he talked to his mom, and sometimes he played with friends.

> I really had set Joey up for misbehaving that morning with my comment the week before about talking about early events—his anxiety must have been way up. It is a fine line between letting children know ahead (greater predictability) and creating anxiety.

I liked Dad's analogy to two motors but realized, when he talked about consequences as the oil to the rusty motor, that I had unfortunately been using the model of learned behavior with the parents too much and been ignoring the model of dissociation. I felt both were playing a role. Joey seemed clearer than his dad with regard to the role of dissociation.

We cannot always do what we have told children we were going to do, but when something does not happen (talking about early events), we need to acknowledge and explain. Keeping the world as predictable as possible, rather than hit and miss, is important.

Developing the Timeline

Two weeks later, we all met together to make a timeline of the events in Joey's life. For most of the session, Joey sat behind the seat where I was sitting (this is the section of the room with the sand tray and other play objects) and not on the couch where he had always previously sat with his parents. We listed something positive and something negative for each year of his life. At the end of the story, I asked Joey what he was thinking, and he said he wished he could have beaten up his birth father and protected his birth mother. I supported him in that wish but noted that kids are not able to stop adults, that it was not his job to stop his birth father. Joey then said he wished he could have asked his birth father why he did it.

I talked a bit about how we were going to use the good events and the negative events on the timeline. I described Eye Movement Desensitization and Reprocessing (EMDR) (Adler-Tapia and Settle, 2008; Shapiro, 1995; Wieland, 2006)—what it was like and what it seemed to be able to accomplish. I had Joey and his parents try out the pulsars I use with children of Joey's age.

I use a timeline as a way of being sure that some of the less blatant traumas are not missed and also making sure the good times are included. It certainly helps me to stay on track—there are always many distractions during therapy and important events can so easily be missed. Thankfully, there appears to be generalization as traumas are processed—all specific traumas do not need to be processed (Briere, 1992). But when there is complex trauma (and this is usually the situation with dissociation), the different types of trauma (being rejected by his birth father, his birth mother's murder, fear of being killed, sadness, and loss) do need processing.

Joey was protecting himself by removing himself physically from the telling of the story. For a child who had been diagnosed with ADHD, Joey certainly was quiet and attentive during the session. He also was very much

present, as indicated by his comments at the end. I felt it was too early in the processing to ask Joey to pursue his question for his birth father. I would, however, need to remember that question for another time. I wrote it on a sticky note and put it on the front page of the file—questions such as that can get buried under pages of notes.

I find EMDR very helpful for processing trauma—particularly trauma from when the child was still nonverbal. My experience is that considerable resolution takes place. It might have been better if I had introduced EMDR earlier in the therapeutic process. Perhaps I could have used it to build resources, or process the negative emotions related to feeling retarded or "bad" as his birth father had been. But I had not and too much energy should not be spent on what we might have done differently.

Although some therapeutic decisions can be made ahead as we analyze a case in our head or in consultation, many therapeutic decisions are made in the moment. The more present we are in the moment, the better the decisions are, but the reality is that we are not always able to be that present.

Working on the Timeline

The next week, Mom commented on how well Joey had done after the last session. In fact, the week had been very good until this morning, when Joey had "lied" and had lost the chance to play with siblings or friends until noon.

I asked Mom when she had first held Joey. She talked about visiting the birth mom in the hospital within hours of Joey's birth and how she had held Joey then. She talked about what a lovely baby he was. After Mom left the room, I asked Joey to draw a picture of his mom holding the baby him. He refused. He was very agitated. I asked if he would find the work easier if his mom were in the room with him. He nodded, and I invited her back in.

I asked him what was a safe place for him, and he named his house. I asked him which room in his house, and he named his room. I explained I wanted him to picture his room while he held the pulsars. Joey complained that the pulsars hurt his hands. I turned the pulse all the way down but Joey still complained. I suggested he put them in his socks and this he was able to tolerate. When I asked him to bring up a picture of his room in his mind, Joey got an image of the outside of the side of his house. He could see his window and told me in response to my question that the curtains were blue. He could picture himself coming home and the house was locked but he had a spare key. In response to questions, he was able, with the pulsars still going slowly, to describe everyone coming home. They were all in separate rooms—Joey was in his room working with LEGO®s.

I asked him to picture everyone at dinner and tell me where each person was sitting at the table. He seemed to soften a bit at that point.

> Joey was very resistant at the beginning of this session. I feel this highlighted the error I had made in not introducing EMDR earlier. There was too much unknown for him at this point. I was not aware of Joey having any extra tactile sensitivity. The sensitivity he expressed may have been a way to resist the work or, given that I had talked about the infant him, may have been infant sensitivity.
>
> I was trying at this point to establish and reinforce a safe place (Shapiro, 1995). I was concerned when Joey's image was the outside of his house (note the contrast between his verbal mention of his room and his nonverbal image of the outside) and that no one was home. Joey still did not have a strong sense of safety. Imaging can be a very powerful tool for providing important information to the therapist. It also provides a way of processing trauma when a therapist is not trained in EMDR (Wieland, 1998). I introduced some guided imagery when I asked him to bring the other family members home and then, later on, have them at dinner. Guided imagery can be tricky. No therapist can know all the facets of an individual's negative experiences and may inadvertently put an individual into an abuse or neglect scenario. In this case, I knew the family ate together, and I wanted Joey to gain a sense of support from the family. It was for this reason that I asked him to move from the image he had of everyone in their own rooms to the dinner table. Perhaps the softening I observed at the end reflected some increased sense of safety.

The following week, Mom reported that, over the weekend, the family had "celebrated" the birth mom's birthday with the maternal grandparents, as they did every year. Grandfather always insisted on a ritual where each person would say what they remembered about the birth mother and then let a balloon go into the sky. Joey's older sister had said she did not want to do the ritual, she had her family now and wanted to move on from what had happened. Mom told her parents they would always remember the birth mother but emphasizing it every year did not help the children. Everyone had become quite angry and the family had left. Mom was in tears at this point. Joey's head was on the back of the couch and his arms were covering his face. I noted to him that his mom needed a hug, and Joey moved over next to her and gave her a long, warm hug. Mom said the grandfather had made plans to play golf with Joey today and Joey was feeling very anxious because he was afraid the grandfather would want to talk about his birth mother. I supported the idea that Joey should be the person to determine whether he spent time with his grandfather or not.

I also clarified that, in therapy, Joey did not need to talk about his birth mother unless he wanted to, but that we would be processing some of the positive and negatives things that happened with her. I named some of the positive and negative times.

I asked Joey if he wanted his mom to stay in the room while he did his safe place. He said yes, and his mom remained at the opposite end of the couch. Joey's complaints about the pulsars were less this week. His image started on the inside of the house, and he had himself and his brother playing together on the computer. The rest of the family was in separate rooms.

After we finished with that, Joey said to me, "Aren't we going to do the writing down stuff?" I asked Joey to draw a picture of his birth mom holding him. This took a long time.

I then asked him to put his now mom in the picture. When he had done this, I asked him what his birth mom was saying. "Here he is, he's yours." Mom looked at Joey with the most amazed look on her face, tears rolling down her cheek. I asked her what she would say. "Thank you. I love him." (At this point, I was also wiping tears from my eyes.) I asked Joey to look at the picture and told him I was going to be turning on the pulsars faster. Following this, Joey chose to have his mom stay during his time and used the time to show her the things in his box. As they left, Mom hugged me. We both had tears in our eyes.

> This was one of the most amazing therapy sessions I have ever had and reinforced what we know but too often forget—children know what they need to do to process trauma and simply need to have a setting provided to them. Joey had gone way beyond what I had hoped for with my question. It felt as if Joey had filled at least some of the loss that had been there for years and years. The attachment between Joey and his now mom was secure and strong.
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> When I use EMDR with children, I often just have them focus on the drawing, or on the image in their head, rather than ask for a negative or positive cognition. My experience is that the child "knows" what needs doing. I usually ask for what they noticed during the time the pulsars were on. In this case, I did not. What had already been said was so powerful, I did not want to lessen it.

Working with the Dissociation

During the week, Joey had, with two older boys, entered the school, taken some fire extinguishers, sprayed some computers, taken the fire extinguishers out of the school, and hidden them. Joey kept saying, while



Figure 5.11 The two parts of Joey. (Used with permission.)

his mom was talking, "I knew I shouldn't do it, I just did." I asked him to draw the part of him that knew he should not do it at one side of the paper and then, when he had done that, to draw the part of him that did it at the other side (Figure 5.11).

I asked what each part was saying and, as Joey told me, I wrote it on his picture in a speech bubble. I asked him to tell me more about the part that thinks stealing is good. Joey said that part thought stealing was cool and that part had guts. I wrote each of those down. I asked how that part could help the other part—the part that thought stealing was bad—to be cool. I reminded him of his skim boarding and he drew a picture of his board under the other part of him. I noted how it had taken guts for him to draw the picture of his birth mom and his now mom the week before—maybe the part with guts had helped him with that.

Then Joey scratched out the face of the stealing guy, but I reminded him that we needed him. He had really helped Joey let everyone know that his world was not a happy one, that he was missing things, perhaps missing his birth mother. We still needed this part of Joey because it had the coolness and the guts to help the other parts of him. While I talked, Joey was doodling several different faces on the sheet. He was also changing

the mouth on one of the faces. I noted that there seemed to have been an angry mouth, maybe a sad or scared mouth, and a happy mouth—and that, yes, all these feelings could exist inside one him.

Unfortunately, there was not time to talk about the other faces.

We could speculate that the extremely positive aspect of the previous session triggered the more negative behavior. Was the part of Joey that had been so defiant over the years feeling ignored? It certainly helped to bring the dissociation back into focus. What was important was that Joey should not come out of this session trying to get rid of the defiant part. Rather, the defiant part needed to be appreciated for having helped him survive the years of loss, and then we needed the different parts working together (Silberg, 2013; Wieland and Silberg, 2013).

I had speculated that most of Joey's negative behaviors included stealing because he was trying to fill his early loss. The comments by the part of him that decided to go into the school and steal the extinguishers did not support that hypothesis. Rather, that part expressed values and thinking that were opposite to the family in which he had grown up. Were these the teachings from his birth father that had never been talked about and had stayed unchanged inside him? Had Joey needed to dissociate the part of him that was the internalized father because the rest of him hated the birth father so much? So much is unknown about the human psychic process.

We had not had time to talk about the other faces. I was struck by the one with only eyes. Was that the 2-year-old Joey who never had a chance to talk about what had happened? Then there were the cartoon features without a facial outline—was this him trying to put on a happy front? And the circle with nothing in it—was this another face? There was so much yet to learn about Joey, and so much for him to learn about himself. What was important in this session was the emphasis on parts working together.

The next week, Mom reported Joey was doing very well. He and the other boys had been given community service hours for stealing the fire extinguishers and there were no complaints from Joey. Joey had also started at the new school and was doing well. Mom's only complaint was his loudness in the morning. She said she tries to ignore it until it becomes too much, then there is conflict. I encouraged Mom to analyze what goes wrong, create clear guidelines for Joey with consequences, explain the guidelines, and follow through with consequences. I encouraged her not to wait until "it becomes too much."

I spent the next part of the session doing an interview with Joey with regard to legalization of the adoption. A psychologist interview and report are required by provincial law. When I asked him what being legally

adopted and officially having his mom and dad's name would mean to him, he said, "Then I won't be the son of a murderer." Joey was clear on his mom and dad loving him.

This session felt as though we were back at the first stage of therapy—establishing stability. But the difficulty—loudness—was farther down the list of difficulties than the lying and stealing we had been working with. I continued to wonder if morning being a difficult time was connected to the birth mother's murder—the children were awakened (although it was night, being woken would mean morning to them) and taken out of the house by people they barely knew, and then later in the morning were told their mother was dead. We clearly needed to move on with processing the timeline information. I have had cases where other issues kept getting in the way of timeline processing—the result was no real progress until we got back to the timeline. I am often unsure whether it is the client or myself who is being resistant. Bringing up old traumas is the hardest part of this work for me. Once brought up I am fine, but bringing it up is altogether different—no one wants to be the one to open old wounds. Doing this work requires a firm belief in the value of trauma processing.

Joey's response about his connection with his birth father also reminded me of the amount of work that remained to be done. Although a legal paper would change Joey's status in the external world, it would not change his internal world.

We had Mom back in at the end of the session. I asked Joey to imagine a safe place for himself while holding the pulsars in his hands. He saw his house from above and was able to look in the window at the family, including himself, doing something together. Unfortunately, that was all the time we had.

Joey's image of a safe place indicated both safety and dissociation (depersonalization—being outside himself while observing himself).

Timeline

Because of my holidays and his mom's schedule, it was five weeks before I met with Joey again. I was anxious to see how things were going. Mom reported that the mornings were still difficult, so we did a bit of fine-tuning related to that. I was determined to get back to the timeline.

We decided to do the time from when Joey was a 2-year-old and his parents would fight. First, we did a safe place with Joey at home with his

now family. I then asked Joey to draw a picture of his birth parents fighting. What immediately struck me was that he had the parents in bed and a lamp was falling off the table—the scene of father murdering mother.

I asked Joey to look at the picture while he held the pulsars in his hands. When I asked him what came into his mind, he said, "Mom dying." After the next set of EMDR, Joey said, "Father making fun of mother." After the next set, "Father laughing at mother." After the next set, Joey said, "Nothing else." I asked him who was here in the room with him now, and he replied, "Mom." We used the pulsars on slow speed with that thought.

During Joey's time, he asked for a drink of water and wandered around the room, looking in his box but not settling to any activity.

As with Joey's earlier picture, I was amazed with the content. He had immediately gone to the night when his birth mother was killed. Interestingly, although his mom and dad had told me about the lamp falling, Joey had not been there at that time and this was not part of the description they gave when we were writing the timeline with Joey. Joey was processing the actual experience.

When Joey responded, "Nothing else," I should have gone back to the first image—the drawing. This was definitely an error on my part, and I am not sure why I made it. Was I feeling overwhelmed with the work Joey was doing? I would need to talk with a colleague about that.

I was interested that Joey asked for a drink of water. If children show an interest in the baby bottles that are among the play objects in the room, I ask if they want one for their box. I have had children Joey's age have a bottle in their box. Joey had never shown any interest in the baby bottles and I was not surprised because he had clearly experienced good attachment with his birth mother during the early years. It was interesting that he asked for water at this point—the point in the timeline when he lost his attachment object. I gave him a regular water bottle that he could then keep in his box for refilling, if he wished.

Attachment Work

Both Mom and Dad came to the next session. Joey was continuing to do well in school and his grades had improved considerably from last year. Dad focused on Joey forgetting to bring his homework home. I suggested more attention needed to be focused on the positive things that were happening. Mom and Dad were sitting on either side of Joey. I asked them to tap his legs slowly and alternately with comments about his being smart, a good kid, and doing well. I then had them tap on his legs with the statement, "I love you." Joey then tapped alternately on their legs with,

"I love you." I suggested Mom tell Joey each night before he went to sleep where she was going to be in the morning (shift work meant she was sometimes there and sometimes not) and when she would see him next. During our conversation, I learned that Joey came out to the living room after he got ready for bed to say goodnight, rather than a parent going into his room to tuck him into bed. I suggested whichever parent was home should tuck him in and explain about the next morning. Joey then asked his parents if he could go to work with them some day.

I asked Joey if he wanted his parents to stay in the room while he had his time, or if he wanted them to be out in the waiting room. He said he wanted them to stay. I said he needed to choose the activity and then tell each of them what to do. Joey chose painting, and we moved the hard plastic sheet that sits on top of a chest with the paints onto the floor so all three could be around the sheet. Joey told his father to paint a tree and his mother to paint a house. When Mom asked what else she should paint, Joey said some clouds.

Joey watched them until they finished and then painted a tree with clouds.

We left all the pictures out to dry. I would put them in Joey's box after they dried.

As far as day-to-day events, morning was the hard time. I continued to feel it was a trigger for danger and loss. Mom's inconsistent schedule unfortunately added to the trigger. Even when his mom was there, Joey would have woken up with the question, "Where is Mom?" My suggestions during this session were an effort to eliminate the trigger, to make the morning a safer time.

Having the family paint together with the child telling the parents what to paint is an attachment-building activity. I found Joey's choices fascinating. He had his dad paint a tree, the symbol in the HTP Projective Test of the self. He had his mom paint a house, the symbol of the family (Knoff, 2003). I felt Joey wanted an image other than that of his birth father to identify with. (I was remembering his comment from two months earlier—"I won't be the son of a murderer.") I was amazed, as I am so often by what children do, by what Joey painted—a tree (a part of his dad's picture) and a cloud (a part of his mom's picture). Yes, he was pulling each of them into himself.

I made a note to myself to go back to the timeline at the next session. I had talked to some colleagues about the possible effect on Joey of his birth father putting the body cologne on him. They had suggested we plan some ritual whereby Joey would throw away a container of his birth father's cologne and then Dad could give Joey some of his. It seemed to me we should do some EMDR processing around the birth father's behavior and then the ritual.

Processing

His mom gave another good report on Joey; she had said he was upset because a girl he had liked had dumped him. Joey did not want to talk about it in the session, but his mom reported that he had talked to her about how he felt. No obsessing was reported. Mom reported that the mornings were going better since she had started telling Joey the night before where she would be and when she would be home. I asked if there was any picture of Joey and Mom that he could put on his bedside table. Mom could not think of any picture with just the two of them. Joey wanted to take one with my camera, which we did and then printed out for them to take home. Mom reported that Joey's sister was having a difficult time getting Joey to leave on time for school. His sister had been talking to the school counselor and was quite upset. But, his mom stated, I did not need to be concerned because the school counselor was going to be talking to the two of them about this. I asked permission to talk to the counselor.

Joey said he wanted his mom to stay in the room during his time. Joey walked over to his box and said, "I'm going to make perfume." It took me a moment to get over my surprise and then I said that his making perfume made me think of when he and his sister went to visit his birth father and his birth father put his cologne on Joey and his birth mother's perfume on his sister. I wondered if he would like to do some ritual to get rid of his birth father's cologne, such as throwing a can of it into the ocean, and then Joey could use some of his dad's. Joey's response was that this would pollute the ocean, and his mom's response was that Dad did not use body cologne. I asked Joey what he and his dad might do with the cologne to get rid of it. The idea of exploding it in a fire came up—I suggested Joey and his dad plan something. Joey then went on to create a mixture of several different paints, some water, and some chalk dust—this was done in an old baby bottle. We then went to wash the bottle.

Children never cease to amaze me—Joey knew what needed working on. I was having to race to keep up with him. Joey wanting his mom to stay in the room seemed like something for the very young Joey—the importance of being watched and held in memory. It was interesting that Joey chose a baby bottle, not one of the paint cups, for creating his mixture. It was clearly about the early period in his life.

I was concerned about Joey's older sister having to be responsible for him. This seemed to be an unfair role for her, especially remembering that she, too, had lost a mother. I spoke with the school counselor who let me know that Joey's sister had had to change schools this fall because the parents wanted someone to keep an eye on Joey in his new school. I suggested that the two children should not be linked together at school—any questions with regard to Joey should go directly to his parents and not

> go through his sister. Responsibility for Joey getting to school should be Joey's and not his sister's. Evidently the parents were asking Joey's sister to report every evening on how Joey had done in school. It was agreed I would call the parents and ask them not to have the sister do this. The counselor let me know Joey was having an excellent year—none of the problems from last year (swearing, hitting, stealing, running out of class, poor academic work) were happening. She would continue to meet with Joey's sister to give her support but would not meet with the two together—thus helping to create a separation between them at school. I then placed a call to the parents.

Following the last session, the first instance of hitting this year at school happened. Another boy had called Joey's ex-girlfriend a "whore." Evidently, Joey had first told him to stop and then when he did not, Joey hit him. Joey told his mom about what had happened before the school called her. This pleased her. I said I could understand how that word applied to someone he had liked would upset him and would really get his angry part going. Did the thinking part of him have any advice for the angry part? Joey was playing at that point, as he often did, with some of the squishy balls. I had Joey use two squishy balls (the one shaped like a lion was the angry part and the one shaped like a pig was the thinking part) to do a puppet show of the angry part and thinking part talking together about this. Joey did an excellent job of this.

Mom talked about limiting Joey to his room on weekend mornings because he had again started taking food he was not supposed to. I responded by suggesting some ways Joey could earn coming out earlier by not taking food. Then I learned that the picture of Mom and Joey had stayed in the van all week.

Mom reported that the dad and Joey had talked some about the cologne but nothing had actually happened. Mom reported that the next week was really busy and she did not see how Dad and Joey would be able to do anything over the next week. I decided to cancel the appointment scheduled for the next week saying that I felt it was important for the ritual to happen before we met again.

The next session started with Mom reporting that Joey had been fighting again at school. It was unclear what had started the fight. Joey felt the other boy had pushed first, but he certainly remembered his own punching and swearing. I asked him how his body felt when he was punching and swearing. He was able to tell me that his body had felt tight, and I asked him to bring that tightness in and then to have his body loosen. Joey did this several times but kept his head under the pillow all the time. I then asked Mom and Joey to role-play the scene with Joey first being the other boy and then himself. Joey participated but in an exaggerated and mocking manner.

Mom then told about Joey smashing the jar of cologne with a hammer in Dad's workshop. This had happened just the night before. It had been just Joey and his dad, but Dad had told Mom about it. Joey told me he had gotten a glass sliver in his finger. Mom was surprised. Joey said there had been blood, but his mom said she had not seen anything and his dad had not mentioned it. Joey showed her a small mark on his finger. Joey said smashing the bottle caused pollution. "The workshop smelled of [my birth father] and who would want that?" I commented that workshops can air out. The air can be good again. I also commented on the fact that Joey had left the workshop and his dad had done the cleaning up in order that Joey not be hurt by the glass.

With the pulsars, we did a safe place and Joey imagined his house with Christmas lights. He was not in the image, so I asked him to take himself in bit by bit—first, he reported seeing his head, then his body, and so on. Joey delightedly told me at the end that he had missed his toes. Working further with the timeline, I asked him to draw a picture of the visits with his birth dad after his move to his now home.

He drew his birth father on the left, his sister on the right, and himself at the top (his head was partially off the page). I noted that he did not have eyes. Joey said he did and redid two dots. He said there was no room for his head. I asked about the object in his birth father's hand. Joey said it was a knife (his mom was startled). I noted that it seemed as if the children were scared each time they visited that they might be killed.

Joey put the pulsars in his shoes before we started the EMDR. During the EMDR, Joey scribbled out his birth father's face, did circles around and around the knife until it was blacked out, and then put smiles on his face and his sister's face.

I wondered if the content of the last session had made Joey extra sensitive to the name calling at school. But given that "whore" was one of the words Joey would have heard his birth father call his birth mother, no extra sensitivity was needed. It did allow for some work related to integrating parts. Role play or puppet play between parts is an excellent way to encourage integration.

I was disappointed when I learned about no picture in Joey's room and then no ritual. I had to catch myself from saying, "How do you expect Joey's behavior to keep improving if you do not strengthen his sense of safety?" Was I "acting out" when I canceled the next session, or was I emphasizing to Mom the importance of her carrying through on what comes up during the session? I hoped it was the latter but was certainly aware of my irritation and the possibility of the former. Being clearly aware of our irritation is the safest way to avoid "acting out" as therapists (Pearlman and Saakvitne, 1995; Wieland, 1997).

In an earlier session, Joey had reported good awareness of his body sensations, which indicated that there was no dissociation of body feelings. There may, however, be trauma memory held in the body which, when triggered, causes a child to react as if in a trauma situation (Levine and Kline, 2007; Ogden et al., 2006). Perhaps being pushed physically had been a trigger. Why I decided to work with the body reaction rather than the trigger, I am not sure. It is one of those decisions that one makes in the moment and just hopes is right. Tightening and then loosening the body muscles can help move a trauma body memory out (Ogden et al., 2006). Joey covering his face may have been his way of dissociating thought at that point.

With the role play, I was trying to engage more of Joey and also to make sure that alternative solutions were available to him. I was sure his mom and dad had gone over what else he could have done when someone pushed him, but I was not sure that he was "present" for those conversations. Joey's behavior during the role play indicated that he was also not very present for our conversation. But there was something even more here. Joey's behavior during the role play made me think of his parents' descriptions of his birth father. It was the first time I had seen this type of behavior. I was not really sure what might be helpful. Certainly, over the years Joey had been compared with his birth father, and he himself had been making those comparisons when the request for therapy first occurred. Was this a dissociated part that we needed to get to know? As I said that to myself, I remembered that his mom had told me that, when they told Joey his birth father was dead, Joey had said he wished he could have gotten to know him. Was creating a dissociated father part of his way of knowing his birth father? More work needed to be done in relation to Joey's relationship with his birth father.

I was very concerned about Joey's report of the sliver. Whether it actually happened or not (his mom certainly did not think it had), it certainly symbolized Joey's feeling that his birth father was inside him—two indicators in one session. This was the last session before a Christmas break, and I did not want to open something up that I could not process. Besides, I was not quite sure how to follow it up. My comment was an effort to provide the possibility of things getting better. Sometimes, that is the best we can do. When writing my notes, I drew a large arrow to this part with a note to follow up.

The drawing of his and his sister's visits with the birth father brought up a number of Joey's realities that had been overlooked over the years. Joey ending with the smiles on his face and sister's face felt to me like an excellent resolution that needed nothing from me.

We met again a month later. Mom had taken some photos of the complex LEGO® structures Joey had built—impressive, and nice reinforcement from Mom. The major issue was that Joey had gone into his mom's room and taken some gum from her bedside table. When his brother reprimanded him, Joey threatened to say that the brother had suggested it. When his sister reprimanded him, Joey tried to bribe her with money. The family had met together and discussed a consequence for each behavior—stealing, blackmailing, and bribing. What struck me in our conversation was that, when I asked Joey about any voices in his head, he said before taking it there was just the voice saying he wanted it, after there was the voice saying he should not have taken it because he would get into trouble. I wondered where the kind Joey was—the part of him that thought about other people—I had certainly heard about that part from his mom at other times.

There was also an incident at school involving money, which led to considerable "lying" at home before Joey told what happened. Mom said she could always tell when he was "lying." Her conversation with Joey at that point clearly indicated that she was getting very involved with him during these discussions about lying. I was concerned Joey was finding this time reinforcing. I suggested she avoid "why questions" and that she end the conversation if it was clear Joey was "lying." She could tell him to come back when he was ready to talk further about things that had happened. It was during this visit that I heard Mom call Joey "son" for the first time.

It was only when the time had run out that I realized I had not saved time for Joey on his own.

Clearly, no amnesia had happened, but still Joey had the belief that lying was a behavior to be used. With the blackmailing, bribing, and lying, in addition to taking other people's things, we seemed to be looking at some very sophisticated behavior—behaviors he had not learned from his present family. Could this have been learned from birth father? I seemed to be back to that same question. Remembering that exposure to birth father had only been the first two years of life and then visits until the age of 3½ years, and the rest of his life (8½ years) had been with the present family, why had new learning not taken place? Was this a dissociated part that, because of the dissociation, had not been able to take in the new learning? Even though the EMDR was clearly helping to process the traumas, it would not address lack of integration. I needed to address more of the dissociation.

Why had I not been more conscious of the time and made sure that Joey had his own time? It was true he had not been making much use of this time recently, but that did not mean it should be eliminated. It was important for reinforcing the value of Joey separate from all the past negative events and the present negative events.

On the morning of the next appointment, the local paper had pictures and headlines of a woman who had been murdered. My immediate thought on seeing the paper was, "What is Joey's reaction to seeing this going to be?"

Dad came in with Joey for this appointment. Joey had, at his own initiative, just started a paper route. He was doing an excellent job of getting up and doing the route, but he was experiencing considerable fear—it was still dark while he did the route and he had several long driveways to go up. Dad and Joey talked about the flashlight he carried, his reflective clothing, that there were other people awake, and what he would do if anyone startled him. Dad talked about being proud of Joey, and Joey talked about when he would be paid and what he wanted to buy. I simply reinforced their discussion.

Dad talked about Joey doing really well except for lying that continued to occur with an assortment of very small issues such as eating the crust of the pizza. I asked where the lying was coming from, and Joey said it was coming from his head. I asked him to draw a picture of his head and what was being said. This he did and then wrote down "Don't tell the truth" and "Stupid."

Joey said he wanted to get rid of the lying. I said the lying side had worked really hard to keep him out of trouble, so it was very important and should not be gotten rid of. The problem at this point was that it was getting him into more trouble. What if this part of him that had worked so hard to keep him out of trouble now worked together with the part that wanted to tell the truth? Dad supported this idea and said that then Joey would have a whole army working on telling the truth.

Dad then said he had noticed Joey reading the paper in the waiting room. He asked if he had been reading about the woman who was murdered. Joey said that when he had done the paper route that morning, he tripped, and when he looked up he had seen the headlines. I asked what he had thought when he saw it. Joey said he had wondered if she had a family and what had happened to them. I asked if either parent had been there when he got home (his dad had been), and had he talked about it? No, he had not. I commented that talking about things helps to sort them out and have them not get stuck in the fearful part of the brain. Dad asked if Joey remembered the time several years ago when he had told Joey and his sister about a mother who had been killed and the children moved into the aunt's family. Joey, who had been moving around the room, stopped and looked very intently at his dad. Dad said it was important for Joey to know that he was not the only child to have this happen.

Was the scared feeling triggered by having to wake up in the dark (similar to being wakened the night his mother was killed), or was it a normal response for a boy of Joey's age to being outside alone in the dark? He

was able to verbalize his fear and to talk about what he would do if someone came up to him. I decided to treat it as a normal response unless problems developed.

When working with dissociation, it is important to talk about each part, even the negative parts, as having been important and as having served a purpose, which indeed they did—the purpose being to push away the negative experiences and feelings so that the child is not overwhelmed (see Chapter 1). Because children naturally want to get rid of the negative parts, the therapist needs to introduce the idea of keeping those parts and having them work together with other parts in order to help the child. Even though this was important information, it may not have been the best way to use the appointment time. Unfortunately, my analysis of the previous session came a week too late. I wish I had asked whether the part that lied knew about how people in this family do things. I wish I had asked what that part could learn from this family. It never pays just to take notes and not analyze what is going on, especially when working with children who dissociate. Now I have another sticky note at the beginning of this file.

I was so pleased with the dad's question about Joey reading the paper. (I called him later to thank him for asking the question.) What I noticed from Joey's response was that he had connected his seeing the headlines with his having tripped. He did not talk about having gotten hurt from tripping, so maybe there is no concern here. After all, having his birth mother killed certainly was tripping; we just do not want the tripping to be overwhelming.

Back to the Timeline

The paper route was going well. Everything was going well. We took another look at the timeline—one of the things noted at age 2 was the birth father's mother making nasty comments about the birth mother to the children. Joey's picture of this was grandmother yelling at Mom. I asked Joey where he would be.

He took considerable time to draw a car and then told me he did not know who was driving it, but he was the one in the back and his sister was in the middle. I asked Mom about this and she said the grandparents used to pick the children up and then go back to their house. A neighbor supervised the visits once they were at the grandparents' house. (The mom and dad requested supervision after Joey's sister told them the grandmother had been saying nasty things about the birth mother.) I asked Joey whether it was when they were in the car that nasty things were said, and he replied, "Yes."

Joey's safe place was the rec room while he played on the Xbox®. (This was what he was planning to buy with his paper route money.) During

the slow speed EMDR (Joey is now holding the pulsars in his hands with no comment), his brother came in and the two of them played together. Then, turning up the speed of the pulsars, Joey looked at the picture he had drawn. His first response was, "yelling," and after the second set of pulses, Joey said, "Went to the Xbox." I told him to enjoy that and turned the pulsars back to the slow speed. Joey then turned to his mom and said, "I want to buy you . . . (a game Mom really likes)."

During Joey's time, he set up a slide and a jump in the sand tray and then tried to find some object that would go down the slide and jump on its own. Nothing would, so he eventually put a male figure in the canoe and pushed it down the slide, over the jump, around and around through the sand. I commented that, when he was waiting for the objects to do it on their own, nothing happened. But when he decided to direct things, all sorts of things happened—such as his setting the goal of buying the Xbox.

I then said I remembered that way back before Christmas, when he and his dad had smashed the bottle of birth father's body cologne, he had told me he got a sliver of glass in his finger. Joey said that had not happened, that he could not remember it. I replied, "So none of that got in you." Joey nodded.

> What struck me about Joey's picture was how much more solid his mom looked than his grandmother. This may reflect the relative importance of the two of them to Joey, or it may indicate that, with the work in therapy, the aunt/adoptive mother has become more substantive to Joey. Joey's picture was not the event I had asked for—earlier pictures had also not been what I had in my head, but they always turned out to be what Joey needed to work on. The work on this one was done very quickly. It was as though Joey was saying to me, "Let's get back to what is now important in my life—an Xbox." I knew we still needed to do some work around his birth father, but it certainly was feeling as though we were near the end.
>
> What should I make of Joey now saying he did not get a sliver in his hand? Whether it did or did not happen—something felt intrusive at the time but did not feel intrusive now. I could take that sticky off the front of the file.

The next week, Joey shuffled in with his head down. He did not respond to my asking about positive things during the week—his mom had to remind him about those. Joey then muttered to me that he had taken treats out of the freezer and now he would never be out of debt because he owed so much to everyone in the family. The latter was clearly a far bigger issue to him than having taken the treats.

When I asked what was going on in his head when he took them, Joey said, "Just wanting the treats." I asked if there was any other option for

getting the treats. Joey said he could have asked but he knew the answer would be "No," so he took them. He said, "I'm bad." I replied that I remembered him having said before that he thought he was bad like his birth father. I asked Mom what she noticed about Joey, and she mentioned positive things about him, things that made him different from his birth father. I then asked him how long he had lived with birth father. Joey replied, "Two years." I asked how long he had lived with his now father. Joey said, "My real father, ten years." I noted the big difference in time.

I asked Joey to draw a picture of himself. He was very resistant but eventually did it. Mom had talked about a time during the week when Joey had noticed her sad feelings and did something for her. I asked Joey to write that on the picture. He wrote, "I saw Mom down and I gave her a hug." I asked him to write down what happened on Saturday when he did not think about others' feelings and took the treats. Joey refused, so I started writing, "I saw the treats and I don't care about the family so I'll . . ." Joey stopped me, "That's not right." "What should I write down?" I took another piece of paper and wrote as Joey dictated—"I saw the treats and I want them and that's it"—and glued it on top of what I had been writing. I commented that he seemed to be feeling cheated. Mom said that Joey often feels cheated when he is given consequences. I asked if Joey knew ahead what the consequences would be. Mom noted Joey knew he would have to replace the treats, but that Dad had created other consequences as well. I commented to Joey that he had been cheated when he was 2 years old and he lost his mother. Does the part of him that feels cheated know about the love and fun he has in the family now? Joey nodded. I asked him if he wanted to do a safe place and use the pulsars, or whether he wanted a hug from his mom. He said he wanted a hug and moved over next to her, laid his head on her chest, and put his arms around her. I commented on the closeness between them and Joey dropped his hand away from the hugging. I noticed that and commented that I guessed I had talked too much.

At the end of the session, I commented to Joey's mom that is was important for consequences to be known ahead and to be consistent. I suggested that if they felt new consequences were needed, they could sit down with Joey and work on that, or, if it would be helpful, they could come in and we could talk about it here.

Was this a reaction to the previous week? Were things going too well and the internal negative parts staged "an internal rebellion"? I felt discouraged (certainly picking up on Joey's and his mom's discouragement) and very scattered in my thinking. I tried tracking different thoughts/parts in Joey, but Joey made it clear that either he did not experience any internal debate, or he was not going to work on that. Next, there was his comment about being bad which certainly needed attention, but I went off on a sidetrack

with my question about how long with each father. I know why I went there—I wanted to strengthen the internalization of now/real Dad—but I did not follow up and do any work with it, so it became just a diversion.

My thinking was already focused on trying to highlight the two parts of him—noticing others and caring; not noticing others. Joey corrected what I was writing, and his statement highlighted his sense of being cheated, so then I went with that. That is a lot of bouncing around—or is it dissociating on my part? The hug was lovely, but Joey dropping his hand away seemed to me to mean I had missed something.

It is very important for therapists to pay attention to their own reactions, their countertransference (Pearlman and Saakvitne, 1995; Wieland, 1997). So often, if we are not attentive, we can play out the child's present experience, the child's early experience, or how the parent had been with the child during the time trauma happened (Davies and Frawley, 1994; Wieland, 1997). Which was I doing? I was starting on one idea and then getting distracted and going with another. There was no consistency—certainly part of Joey's early experience and also part of the experience at home now. I would need to be more consistent in my questions and responses, thereby providing Joey with a more consistent experience.

I think the changing of consequences is very hard for a child such as Joey—again, lack of consistency. Unexpected things happening can keep a child in the state of hypervigilance and, as in Joey's case, feeling resentful.

Two weeks later I met with Joey's mom and dad. Dad was expressing considerable discouragement. Dad recognized dissociation happening when Joey got angry, and could see a clear flip in how Joey responded, but he felt that Joey was calculating in his stealing and lying behaviors. I tried to explain that the calculating might be the part of Joey that felt cheated by the world. We talked further about short and consistent consequences and that it was important that all the parts of Joey were aware of these consequences.

When Mom and Joey returned two weeks later, Joey was continuing to have trouble at home. He had been calling his mom names. As we listed the names Joey had been using, he was able to note that Mom was both hurt and angry when he did this. Joey came up with some ideas for consequences.

During Joey's time, I noted that all of him needed to know about the consequences and agree to them, or else one part of him (the part calling names) would get the other part of him (the part receiving the consequences) in trouble. He was able to name the parts that had been there so far during

the session—sad part, angry part, good part, and negotiating part. When I asked him to tell all the parts, Joey took the pieces of plasticine he had been playing with and squeezed them all together and said, "They're together, they're here."

> Joey shifted considerably from the beginning of this session to the end in his level of engagement. It was when I asked him what consequence he thought could help him learn that he actually became engaged. The progress made at the end was clearly connected to the level of engagement. Also, I was better engaged and more consistent.

At the time of the next appointment, Joey had had an excellent two weeks—no name-calling, no stealing, and no lying. Joey expressed a wish to stop therapy, and I suggested we aim at finishing before the summer. With that, we returned to the timeline and looked at Joey at age 3, when he and his sister went to visit his birth father in jail. Mom said that these visits were full of presents and then the children felt they should get presents at home. She noted that during that time, the children often commented that they were half-good and half-bad, saying that the part they got from birth dad was bad. I talked about how children start with inherited genes and then they have experiences that move them in one direction or another. Mom started talking about Joey's birth dad, talking about how his father had chased him around the kitchen with a knife. I noted that frightening behavior was something birth dad learned, but what were Joey's experiences? We listed the experiences with his mom and dad and noted how much Joey was like his now dad. During Joey's time, I suggested that he draw himself in the middle of a page and then put the things he had talked about liking around him. Joey asked if he could draw a tree in the middle of the page, rather than himself. Then, around the tree, he did drawings of himself doing math in his head, making a goal in soccer, looking at things, and his mom playing with his hair. We did some slow EMDR tapping while Joey looked at the picture.

> As I looked back on the session, I recognized an error. I had focused on Joey's good experiences—why had I skipped right over the early, bad experiences when I know that early trauma experiences are held in the right hemisphere (that part of the brain that does not have a sense of past, present, future) and need left hemisphere processing (placed within a past, present, future context) before they can be placed in the past and an individual can move on to now experiences (Brewin, 2005; Schore, 2003)? When Mom mentioned Joey's birth father's childhood experience, I had had a very strong reaction—"So that's where he was coming from."

My second reaction was, "Don't go there," and I did not stop to wonder about this reaction. Was this something about me, or was I picking up Joey's response—both are parts of countertransference (Pearlman and Saakvitne, 1995; Wieland, 1997)? Neither would be wrong—what was wrong was that I did not recognize the countertransference and shift out of it. Rather, I reacted with the countertransference and avoided the hard topic of Joey feeling he was inherently bad.

Avoidance had been the story of Joey's growing up, and this was what had reinforced the dissociation. Avoidance is normal, and even adaptive, when traumatic things happen—Joey's birth father hitting him, his birth father hitting his birth mother, his birth father murdering his birth mother, losing his birth mother, his grandmother criticizing his mom, and visiting the birth father who scared him. Avoidance becomes problematic when it is reinforced over and over again (Silberg, 2013), when there is no soothing, no talking, and no explaining to help the child integrate what has been frightening and what has been lost. Van der Hart et al. (2006), within the structural model of dissociation, describe the dissociated part or emotional part (EP) as that part of the person to which the individual has become phobic. The apparently normal part (ANP) of Joey—Joey without those feelings or experiences to which he had become phobic—continued functioning, albeit with many disruptions caused as the EPs intruded from time to time. Over the time of therapy, we had done considerable work on the feelings and memories that had been dissociated (EPs), thereby reintegrating them into the ANP or central part. Why was I avoiding now? I did not want Joey to equate himself with his birth dad—having frightening experiences as a child and then going on to be a frightening man. Rather than avoiding, I could have explained how early experiences can affect a child and also how, with the help of positive support and soothing, those effects can be shifted

The rest of the session went smoothly. I was struck by Joey wanting to draw a tree in place of himself and recalled that, in the HTP Projective Test, the tree is seen as the symbol of the self (Knoff, 2003). The tree was also what he had his dad draw and then he drew when the family was doing art together.

Again, there was a two-week break. This time Dad came with Joey. Generally, Joey was doing well, but there had been a major incident when Joey was kicking a bottle and it flew up and broke a neighbor's window. Joey ran home crying and, after much upset, told his dad what had happened. Dad helped Joey apologize to the people who lived in the house. Joey showed his dad the list he had made the previous week of the ways he was similar to his dad.

Dad also talked about how life at home was overwhelming. There were four children between the ages of 12 (Joey was 12 at this point) and 18 with all their activities, and none of the children had chores. Mom and Dad both worked, and then came home and did everything. I raised the question of whether some family therapy could help the family rebalance the situation at home. Unfortunately, Dad was not receptive. Joey expressed the wish that I could just see his parents and not him.

> Things seemed to be better, but I was curious about Joey's wish for no more therapy. Was he reacting to my avoidance of difficult topics? Was he wishing his parents would solve the overwhelming situation at home?

The next session followed Mother's Day. The teacher had given an assignment for each student to write a letter to his or her mother about the student's life from age 1 year to the present.

Joey had written two lines:

When I was one year old my father killed my mother.

Twelve years old—if I had been there I would have killed him.

I asked Mom and Dad to talk about things they remembered with Joey from each of the years between 1 and 12. They remembered special times from each of those years.

During Joey's time, I asked if he thinks about saving his birth mother. Joey replied that he had a dream of saving her just a few days ago and also a dream of his cat dying. We talked about what 2-year-olds are able to do and how saving his mother was not something he could have done. It was not something he could do, just as he could not save his cat.

> This becomes a judgment call—to fill in the experiences that the part of Joey who was attached to his birth mother and who suffered the early loss had missed, or to focus on his wish he could have changed the events that happened. Perhaps this is the advantage of having two different halves to the appointment—we were able to follow both the topics.

During the following week, Joey's behavior at home deteriorated—he was taking food before he went to bed and, when he got up in the early morning, denying it. I talked about this behavior as Joey's way of letting his mom and dad know that his world still did not feel okay. The photo we had taken of Joey and his mom that was to be put on his bedside table had never made it there—it had disappeared. We took a new picture, and Joey was very pleased.

I talked about the little part of Joey being scared of people being hurt, or people being taken away. Joey reminded his mom of the time his dad had pushed his older brother down, and the time his dad had dragged his sister off the couch. Mother pointed out the reasons why each of those things happened and that no one was actually hurt. Joey said he wanted to get rid of being scared. I noted that the scared part of him had been important when he was little in letting him know when a situation was bad, maybe the scared part could have a new role now—letting his mother know when something at home feels unsafe to him.

When I asked Joey for a safe place for some EMDR work, he and his brother were in the computer room. Then, Joey added that he heard an explosion upstairs. I suggested he (within the image) go up and see what was happening. Joey reported that his mom and dad were fighting. I asked whether they were hurting each other and Joey replied, "No." I asked if anyone was being taken away, and Joey replied, "No." In his image, Joey went back downstairs and played on the computer. I did slow tapping with that.

I suggested to his mom that she review with Joey each night, as he was going to bed, that his mom and dad do not hurt each other, and that no one gets taken away from the house.

> Joey's fear from the time he was little, which had been dissociated, was intruding into his present experience. Within the language of the structural dissociation model (van der Hart et al., 2006), Joey, to survive, would have had to be phobic of this fear; thus, it would have been dissociated into an emotional part. Not only does the fearful part of him (EP) need to become more aware of his present safer world, but also the central him (ANP) needs to recognize and let others in his life know about his present fears. These thoughts were behind both the EMDR work and the suggestions for home.

At the beginning of the next session, Joey was again hiding behind the pillows. He was saying that he did not want to come to therapy. Mom explained that his dad had taken away a sleepover as a consequence for lying, then started to give it back, but then said, "Sandra would tell me not to give it back, so I won't." I asked Joey what he thought had changed since coming to therapy. He said his grades were better but that was all. I asked Mom to talk about the changes she saw and the ways she was proud of him. She mentioned, among other things, that he was now telling about homework assignments and was completing homework.

We then continued with the timeline looking at the time Joey was 6 years old and his birth father died in jail. I wondered what that would be like for a 6-year-old. Joey said he did not know, and I noted that 6-year-olds are curious and want to know things—what would he have wanted

to know from his birth father? "Did he know what it was like to be hit on the head, what it was like to be killed?" I noticed what important questions those were and how Joey's thinking about the other person made him different from his father. Another difference was Joey starting to take responsibility for things, as he was doing with his homework—his birth father had not taken responsibility for his behavior. Joey shifted to talking about being on medication and saying that proved something was wrong with him. I asked why he was on meds, and he replied, "I can't pay attention and I had lots happen to me." I noted that he was learning to control his attention and he was working through what had happened—in fact, we were almost done.

No wonder Joey did not want to come—he would have seen me as the person who was making life hard for him at home. I could feel the discouragement, as well as irritation with the dad, welling up inside me. We are not alone in our work with children. We are dependent on the parents. I knew both the mom and dad were tired—they were caught in the trap of trying to do everything for their children to make up for what each of the four children had lost—two had lost their birth parents and the other two had lost the sole attention of their parents. I had offered family therapy (with or without the children) with another practitioner in our office several times, but each time the dad had refused. He said he was too worn out to do it. Was he worried that fingers would be pointed at him? That was certainly not my intent—I must be very careful. I needed to help Dad with his overwhelm, not be irritated with him. He, as well as Joey, needed a new more positive experience.

I was pleased with the empathy Joey was starting to experience. Yes, he was different from his birth father.

Before the next session (three weeks later), I received a phone call from the school counselor saying Joey's sister had written a story about a girl whose parents had died and then the girl killed herself so she could be with them. I spoke with Mom alone at the beginning of the session and recommended a therapist. Mom blamed herself for the girl's upset, saying she knew she was hard on her. Recognizing first how much Mom loved all the children and how much she did for each of them, I offered Mom a separate session to talk about the situation, but she chose not to have one.

Joey, on the other hand, was doing well. He had walked away from a fight. During his time, he chose his room at home as his safe place. He said that he thinks a lot about his birth mother and wondered why she did not go to grandmother's house that night. Joey was able to admit to a little bit of anger at his birth mother. He had decided that his birth father had killed his birth mother because she wanted his money.

I suggested we take a break over the summer (it was then the end of June) but asked that the mom call me with updates. During this final discussion, I asked the mom what it was like spending time with Joey, and she responded, "Not bad." Joey looked at her and asked, "Is it fun?" Mom did not respond, and I noted that Joey needed to hear from her that those times were fun for her, not just for him. She then replied that she had fun with him.

Was this the dynamic seen so often in dysfunctional families—when one child gets better, another gets worse? I had not initially seen this family as dysfunctional. Even at this point, I was using the word "exhausted" rather than "dysfunctional." The mom's inability to respond to Joey at the end of the session was disturbing.

But Joey was making progress. Wondering why his birth mother had not done things differently was an important shift from blaming himself for not stopping the murder. Admitting to anger at his birth mother would decrease the need to dissociate anger.

I received no call until the end of July when Mom said everything was falling apart—stealing, lying, breaking rules, and Joey was putting his hands around his own throat and coughing. I was most concerned by this last behavior (his birth father had strangled his birth mother) and asked them to come in. When they arrived, Joey was very upset—I had ruined his summer. He was picking at his fingers, a behavior I had not seen before.

During Joey's time, I asked him what part of him did the action of strangling, and he said, "Bad me." I wondered if he did not want to come because the part he calls "bad" thinks I want to get rid of that part. I said it was important not to shove that part away but to figure out what that part needs. Very reluctantly, he drew a picture. The "bad part" was walking away and the other him was arguing inside his head. I asked what he wanted and wrote out the list he gave. Joey said nothing good was happening this summer.

I spoke with Mom alone at the end and asked about what Joey's activities were this summer. Evidently, there were no planned activities. Mom responded that his sister did not want to spend time with him. His brother, who was four years older, did spend time with him but did not want to. I recommended some planned activities or summer camps, and time with friends.

It felt as if the parents had abdicated and Joey was reverting to old behaviors and even "upping" the situation with the hands around the throat to be noticed. How much of this was dissociation and how much was an upset child who did not feel wanted?

I did not hear from the family again until October. The mom reported that Joey was leaving class when he did not understand the work and when he felt a girl did not like him. The lying and stealing were back up again. The night before they came in, the dad had been angry at Joey and had reacted with some hitting and pushing. Dad was very upset with his reaction and had made an appointment to see his doctor. Meanwhile, Joey's skateboard had been taken away and he felt he would never get it back. Discouragement was everywhere. Mom and I talked about how others in the family need to take responsibility (as the dad was doing today by seeing the doctor) for their behavior.

During Joey's time, I made a diagram with him in the middle and then small drawings of him with the various problem behaviors around the central him. Joey started listing negative things he used to do, and I noted I would not put them down because things from the past were not him now. I asked about the expression for each face, but Joey would not say. I responded by asking what he could say from the center him to each "behavior problem him" and wrote down what Joey told me. I encouraged him to do this talking between parts inside his head.

> It felt as though the family was out of control. Joey was only responsible for his own behaviors, not for others. Encouraging the talking inside is helpful for children who are not dissociative and is essential for children who are dissociative.

When Mom and Joey returned one month later, Mom reported extreme switches in behavior—okay, anger, crying, 2-year-old. Problems in the family were continuing, with Joey feeling he was being the scapegoat. Joey told me he hears his parents arguing and becomes frightened. He could not tell me how old he felt, but it definitely was not 12 years old. Joey could tell me the difference between this dad and his birth father—this dad does not kill anyone. He did not want to tell his mom about the frightened feeling but wanted me to, which I did.

> Even when dissociation decreases or resolves in children, they remain vulnerable when further fright happens and, most particularly, when the fright has some similarity to the original trauma. Back to the safety–stability phase of therapy.

Two weeks later, the situation in the family had improved and Joey was doing better in school. The main issue was Joey taking candy out of the parents' room—when confronted, he admitted it. His parents were telling him he was hurting the people who love him. When Joey and I talked about it, he kept repeating this. Joey did not want to draw a picture but was able

to describe a conversation between the "wanting to take the candy," the "not wanting to take the candy", and the "trying to ask for the candy."

> This certainly sounded more like a behavioral problem than a dissociative response.

There was a break over the Christmas holidays, and I met with Joey and his dad after one month. There had been only one incident of taking candy. Joey was able to describe what happened from the moment he got the thought until he did it. Unfortunately, a thought about how others would feel or consequences never came into this internal process. We talked about how he would feel if his brother took his LEGO®s.

During his own time, Joey decided to paint one of the clay bridges on the toy table. I noted that he seemed to be getting ready to end the therapy and wanted to leave his mark here. He then took a number of different items and mixed them together on the table. I said that reminded me of how he was bringing together the different thoughts and feelings he was having.

> Painting an object in the room is an activity children often do when coming to the end of therapy. The problems in this family were far from solved and some of Joey's difficult behaviors certainly remained but, presently, he was not presenting with dissociation or with PTSD. I felt that prolonging the therapy at this point would keep the emphasis on Joey rather than on the family, where I felt it should be.

Mom called two months later. When they came in, there were good things to report and difficult things to report. Joey's computer and TV privileges had been taken away for one month because he had used the computer after he had been told not to do so. Joey, on his own, told me he would continue to do just that because, "I can't exist without it." When I talked to the mom, on her own, she said that Joey and his brothers were all sneaky—doing things the parents had restricted when the parents were not home—and his sister had other problems. Again, I suggested family therapy, and Mom said they were too tired to do that. I suggested that I meet with the mom and dad.

> Although most of this session felt as though this was a child who was misbehaving because of inconsistent parenting, I was concerned about his statement that he could not exist without something. Loss—whether of a person or an object—seemed to have, understandably, a larger than normal effect on Joey. This is something that we could work on processing with EMDR. But this did not indicate dissociation. In fact, no symptoms of dissociation were being described.

We had not done any formalized integration work, but integration certainly appeared to have occurred. This is not uncommon in children or adolescents where the parts can simply work more and more closely together (Silberg, 2013). While the mom was discouraged, I was encouraged.

I met one week later with Joey's mom and dad. I asked them to describe Joey as he now was. They said he was a delightful child but he continued to take stuff—mostly sweets, or money to buy sweets—and to lie about what he had done. Some of this behavior they thought was impulsive and some was carefully planned. They said this behavior was similar to that of his older brother. The mom and dad were continuing to find it difficult to agree on chores and consequences for all the children, but they were not fighting as much. I talked about how much energy and love they had put into parenting their children but that, now, they needed more participation from all the children. In that they were not interested in any family appointments, we talked about how they could talk with all the children about creating a better functioning family and how they were going to support each other.

I did not hear from the family following this appointment. I did hear from the school counselor who was concerned that Joey was not doing well in school. Interestingly, Joey taking things was not happening at school. I called home and asked for a chance to meet with Joey. I decided to do this session a bit differently. I met with Joey for the whole session. Joey remembered each of the incidents mentioned by the counselor and noted that they had occurred during the first part of the year. He agreed that he was being goofy and he was swearing, but that he could change this on his own. He was tired of working on things in my office and thought he should solve them himself. He chose to spend the last part of the session painting the bottom of the clay bridge he had started painting previously. First, he mixed a bit of all the different colors together and then used this color for painting. I commented on the mixing together and that that was what we had been working on here—having all the bits of him together. I congratulated him on wanting to now take charge of his own behavior.

Joey's parents had originally contacted me regarding therapy for Joey, not for assistance in parenting. Although originally they had seemed open to suggestions, at this point the stress and discouragement in the family seemed to be blocking any work in this area. The most I seemed to be able to do was to reinforce how much they had given to their children.

My decision to meet alone with Joey came from my wish not to get caught in the family dynamics. The parents' decision not to follow up with family work was clear, and I did not feel another session going through those dynamics was going to change anything.

I wanted a chance to reassess Joey and to ask him what he wanted to work on. He reported good recall of events and did not report any arguing in his head or loss of time. I did not discern any symptoms of dissociation. I felt that his wanting to work on his problems himself was a positive step. My office was connected with Joey's past and now he was in the present.

I did not hear from the parents again. At the end of the school year (two months later), I called Joey's mom to find out how things were going. She said she had a call from the teacher saying how well Joey had done. She said similar problems continued at home but that she and Dad were working on being clearer and more consistent.

I sent Joey a note to say good-bye. I mentioned all the hard work he had done and sent him best wishes for the years ahead. The notepaper had a beach scene on the front. I told him I chose that because when I see sand beaches I think of his description of skim boarding on beaches.

Good-byes are important for everyone, and particularly so for someone who has had an unexpected loss. As I wrote the final report to the funding agency, I noted the good work Joey had done but also noted that further developmental stages (advanced puberty) and events (intimate relationships and losses) may retrigger the early loss of his birth mother and may require further short-term therapy. I felt I could say "short-term" because much of the trauma had been processed, and much, if not all, of the dissociation had been integrated.

Looking Back at the Therapy

Although Joey had done some excellent work during the therapy, problems both for him and for the family continue. His extreme shifts of behavior (dissociation) had disappeared, his ability to talk about what he had done and how he felt (association) had increased, his obsessing on girls had not reoccurred, and his wish to be in control of himself had strengthened. Problems at home, particularly with taking food, were continuing. Children often take objects within the family setting when they feel they are missing something within the family. I felt, at this point, these behaviors were more connected with the present family dynamics than with Joey's past. To continue to see Joey would distract from the need for attention to the dysfunctional family dynamics.

In retrospect, I wish I had done more family work at the beginning. Joey's initial difficulty finding an image for safety within the home (he had imaged the house from the outside) and with the family together (he had imaged each in their own room) could have alerted me to the need for

family work. I had assumed that the dissociation was blocking his internalization of a present safe world. This will be a reminder to me in the future to be more alert to present family dynamics.

Editor's Comment

In contrast with the previous chapters, Wieland describes therapy with a boy with dissociative disorder not elsewhere classified. Joey presents with sudden shifts in mood and behavior, inability to understand his own behavior, voices telling him to steal and lie, and shifting attachment patterns with his parents. In the assessment drawings, Joey draws two different trees (one in the place of the other) and two different boy figures. Joey, however, recognizes body sensations, has clear experience of anger at his birth father and deep sadness connected to the loss of birth mother, and recalls much of what he does. It can be speculated that Joey's early positive attachment with his birth mother, which he was later able to experience with his aunt/adoptive mother, was able to provide protection from more extreme dissociation (DID).

Although Joey is 11 and 12 years old during the time of therapy, Wieland encourages activities (drawings, sand tray, puppet play, crafts) that are more often included within play therapy for younger children. This reflects her wish to engage right hemisphere processing. This is an important emphasis based on Schore's work (2013)—which highlights that dissociation is a dysfunction in the right pre-frontal and limbic systems, and on Perry's work (2006)—which indicates the need for activities developmentally appropriate for the age of the child at the time of the trauma. The importance of not only physical safety but a clear sense of safety that needs to be felt by all the parts of the child (the 2-year-old part as well as the 11-year-old part) is emphasized. Without this, Joey's HPA and ANS systems would remain "on alert" and he would easily be triggered into emotional over-arousal, with little ability to control his behavior. Before engaging in any of the trauma processing with EMDR, Wieland directs Joey to first find a safe place and uses slow bilateral stimulation to help strengthen his sense of safety. The safe place images do, indeed, become stronger and do, over time, provide more connection with others (important for countering the internal distress that comes with loss). Joey's drawings during the EMDR trauma processing often move beyond what Wieland was thinking about to the very core of the trauma Joey had experienced. This highlights how the right hemisphere is able to express the trauma (Chapman, 2014) and, once supported with verbalization (left hemisphere), the trauma can more easily be placed within the context of the individual's ongoing life (Brewin, 2005).

Wieland's use of the timeline for processing trauma is quite different from the work in the previously described therapies, where trauma was addressed as it appeared in the child's recall of memories (Dalma) or

observed behaviors (Jason and Ryan). Writing out the timeline enabled the family to recall a number of traumatizing events that previously had been overshadowed by the trauma of the murder. Perhaps most striking in the therapy was Joey's own wisdom—moving the focus of the therapy to what needed to be processed (the murder scene, his birth father's cologne).

Wieland describes for us the quandary therapists often face when trying to determine what is the basis of a particular reaction or behavior—was Joey's behavior reflecting a genetic characteristic, a learned behavior based perhaps on the activity of mirror neurons, or a psychic injury (needing to fill the "emptiness" left by his birth mother's death). Knowing the basis of a behavior helps to guide a therapist in her work—with a genetic basis, an individual can be helped to be aware of the characteristic and determine how to use it or to control it; with a learned basis, the individual can be encouraged to engage in new noticing and learning; with a psychic basis, the individual needs both imaged and real experiences to counter the wound. At different times through the therapy, Wieland uses different approaches.

As highlighted by the writings of Perry (Perry and Dobson, 2013) and Schore (2012), work with the family is an important part of providing a child with the experiences needed for neurobiological repair. In the dyad sessions with Joey and his mom or his dad, and in sessions separately with the parents, Wieland encourages the parents to become clearer and more consistent in their interactions with Joey, thereby providing him with a more stable world, an essential requirement if his HPA and ANS systems are to calm. Noting the effect on Joey from his mom's off-hand comments, her absence in the morning, and the distressed family dynamics, Wieland encourages the parents to become more supportive and to engage in more positive attachment activities—important for right hemisphere repair. With positive right hemisphere stimulation, that area relevant to self-awareness and self-identity receives strengthening (Schore, 2012).

Within this case presentation, Wieland uses diagrams based on the ego-state model (Watkins and Watkins, 1993) and explanations congruent with principles from the Affect Avoidance Theory (Silberg, 2013) to explain dissociation to Joey and his mother. She refers to structural dissociation (van der Hart et al., 2006) when she reflects on helping Joey be less phobic to negative feelings and strong reactions that could not be processed at the time of trauma and when she reflects on the importance of the therapist not being phobic to the child's hurt.

Although Liotti's model of disorganized attachment (Liotti, 1999) would not have applied to Joey's pattern of attachment to his birth mother, it may have been extremely relevant (although Wieland did not speculate on this) with regard to his attachment to a father figure. Joey's difficulty shifting from "I am bad like my father" may reflect this disorganized attachment. Wieland comments on how the apparent secure attachment

with the birth mother had seemed to transfer to his mom. Perhaps the disorganized attachment to his birth father transferred to his dad. Even though Wieland did some attachment work with Joey and his dad, perhaps the therapy would have proceeded more smoothly—and possibly with less resistance from the dad—had more attention been given to their attachment relationship.

Although Putnam's discrete behavioral state model (1997) does not appear to play a direct role in Wieland's conceptualization of Joey's therapy, her emphasis on internal communication—which is highlighted in Putnam's model—can clearly be seen.

A major theme running through this case is the challenge of working with well-meaning parents who are caught within a demanding and exhausting lifestyle. This lifestyle, however caring, is also somewhat dysfunctional—inconsistent responding to the children, arguing between parents that is not explained to the children, and some physical pushing between the dad and the older children. The parents' unwillingness to engage in family therapy limits the progress that can be made in Joey's therapy. As Wieland points out, if these problems had been addressed earlier in the therapy, they might not have become so disruptive to the therapy process. Although the mom reported that she had received some therapy following her sister's death, the question arises as to how much her trauma response to the murder of her sister may have played into the family dynamics.

Wieland recognizes possible countertransference responses in several places. She highlights, as did Marks (see Chapter 3), that working with children with dissociation can create scattered thoughts or resistance to the trauma for the therapist. Although Wieland did not have an opportunity for ongoing consultation, as did Marks, she notes several times when she sought consultation to help her process what was happening, or what to do next.

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6 Angela (14 to 16 Years Old)—Finding Words for Pain

Treatment of a Dissociative Teen Presenting with Medical Trauma

Joyanna Silberg

Fourteen-year-old Angela looked like a scarecrow when she came to her first appointment—skin pale as snow, no eyebrows, a long-haired blonde wig topping a frail 5-foot frame. Her mother had called me two weeks earlier, stating that her daughter had changed dramatically since battling a long abdominal illness. Angela, previously a timid, soft-spoken, reliable teenager, was now making rude, sarcastic comments to her mother and friends, did not follow through with plans, and was forgetting to do homework and chores. Even though these behaviors were not out of the range for normal teenage behavior, to Mrs. Stein, these were severely out of character behaviors for her straight "A," prim, and proper daughter.

The call from Mrs. Stein had been followed by a call from Angela's treating therapist for several years. Dr. Falk explained that he had a long-standing relationship with the family, who had come to him over the years at times of family crisis. An older brother had been arrested when he accompanied some other teens on a break-in at a 7–11, and he had helped advise the family about dealing with the legal system and counseled the brother, who had since turned his life around and was in college. Dr. Falk had been seeing Angela off and on throughout her protracted illness, to help her cope with the stress of falling behind in school. Recently, Angela had told Dr. Falk that she was upset by her mother's report of these rude behaviors, did not remember them, and was very worried about her memory in general. Previously an "A" student, she could not remember the content of books she was reading and was falling behind in her accelerated eighth-grade curriculum. Dr. Falk had long suspected that there was much about Angela that he had not uncovered and wanted me to evaluate Angela for a possible dissociative disorder.

After my initial shock at Angela's appearance, I started with the usual ways of making conversation with a girl her age. How do you like school? Who are your friends? What TV shows do you like? How do you get along with your mom? Unlike most girls her age, happy to talk about themselves, their lives and their interests, Angela politely gave one-word answers or

said "I don't know." Talking to Angela was an agonizing process, one in which I was clearly doing all of the work. "How can I get her to loosen up?" I wondered, and I hoped that in our next session she would be more relaxed. I gleaned through the monosyllabic responses that Angela gave me that she was afraid that she might be "losing it," as not being able to read and remember was very upsetting to her. She was upset that her mother thought she was rude, but this was not as important to her as her friends telling her rude things she said to them that she did not remember. When talking about her illness, she was more animated and able to give many medical details. The medical picture was complex but involved weight loss, repeated vomiting, severe abdominal pain, and hair loss. The final diagnosis was abdominal adhesions that attached the appendix to the abdominal wall, complicated by endometriosis. Surgery two months ago had relieved the pain, but her life had not returned to normal. Her hair had fallen out several months ago, and the best guess of the doctors was that it was a stress-related response. Ongoing evaluation of autoimmune diseases had not yielded any results. Her hair loss did not bother her, she stated, as her mother had bought her a variety of wigs. As she told the story, she emphasized that her mother had not acted quickly enough and was not "smart enough" to find the right specialists. I made a mental note that the feelings about being let down by her mother would need to be explored further. Angela explained that she had needed to be hospitalized on six occasions in the past eighteen months, and had been put on heavy doses of pain medication. Much of the last year had been spent, however, laying on her bed at home, just praying for the pain to go away, and wishing her mother could find a doctor who might determine what was wrong. I noted she talked about her illness in a mature and medically specific way, and unlike her talk about anything else, some affect was present expressing an underlying anger and disappointment. Noting her generally affectless presentation, I amplified the feelings she expressed—stating things such as, "How horrible that no one could figure anything out for so long. How helpless and terrible it must have felt to have no one able to solve your problem, even your mother whose job it is to do that." Angela smiled faintly when I said these things, indicating to me that what I said resonated with her in some way. Angela told me after the first session that she wanted to return to see me as, with her previous therapist, she had not figured out anything, and they both sat in silence much of the time. I agreed we would work together to figure things out.

> As described in my Affective Avoidance Theory (Silberg, 2013; see Chapter 1, this volume), in approaching dissociative disorders it is important to assess how adequately the individual handles and processes ongoing affect. Angela's generally emotionless presentation and monosyllabic responses were clues that there may be more intense affect underneath that would

need to be accessed. In this initial interview, I am assessing where the sensitive areas are to help me eventually uncover the issues that are most significant to her. Because she seemed a girl who was "slow to warm up" and clearly very disappointed in professionals, I tried to keep the first session low pressure, building a relationship and helping her feel this was a safe environment. As dissociative clients frequently feel ashamed or phobic of their own affective responses, I try to model how safe it is to express strong feelings of disappointment and helplessness by amplifying what the child expresses. For many clinicians, such an action is counter-intuitive, as often we are told to help children calm down, understand that their parents did everything they could, and not "rock the boat." For someone like Angela, I hypothesize that not "rocking the boat" may have cost her her mental health, and so I will agitate and amplify the feelings, illustrating that it is safe and understandable to have feelings such as these and to help overcome the dissociative avoidance. Angela's smiles told me that these areas would need to be explored in future sessions. I find that the best assessment tool with adolescents is sensitive interviewing that takes place over the course of the first few sessions. Sometimes, I will use assessment tools such as the Adolescent Dissociative Experience Scale (A-DES) (Armstrong et al., 1997) to stimulate disclosures about dissociation that we can talk about further. Angela showed the ability to disclose to me without reliance on these tools.

The Initial Treatment Intervention

I had hoped that we had gotten off to a good start, and Angela would be more forthcoming in the second session, able to relate in a more relaxed manner. Instead, she gave me the same monosyllabic responses in answer to questions such as: How was your week? and How do you feel? I asked her if she could tell me more about her worries about rudeness to her friends, and if that had happened during the past week. Finally, in a matter of fact way without much affect, she told me her best friend was not talking to her anymore, as her friend reported Angela had "cussed her out" and made fun of her boyfriend. Angela was quite sure she had not done this and thought her friend was "weird" for suddenly turning on her. I asked if it bothered her to have her friend "ditch" her like that and whether she worried that maybe there was some truth to the accusations about what Angela had said to her friend. Angela was intensely insistent that she would "never treat a person like this."

I puzzled aloud with her how strange it was that both her mother and her best friend reported hearing things from Angela that she did not remember, that Angela herself could not remember what she was reading,

and that maybe there was a chance that memory problems could explain this situation. Angela insisted even more forcefully that she would never be rude to people, that it was not her. Playfully, I wondered aloud if it was possible that there was "another Angela," another side of her that might explain it all. Angela became suddenly very serious when I made this comment, and stated, "If she is there, the other Angela is not me." I asked her if she would be willing to do an experiment with me to see if there was another "Angela."

Hesitantly, Angela agreed to try my suggestions. I told her to focus very intently, to close her eyes, and with an attitude of curiosity and not harshness, ask her own mind if there was "another Angela." Angela followed my instructions and kept her eyes closed for about a minute. When she opened her eyes, I asked her if she had "heard" anything, and she said, "This is really weird but I heard a voice say, yes." I praised her for how well she had accomplished that exercise and asked her if she was willing to find out anything more. She said she was really frightened, but figured she better do it, because that was what therapy was for. I told her this time, when she focused on listening to what her mind was telling her, she should say, "Thanks for being there, I must have needed you." Angela followed my instructions and opened her eyes in another minute. Angela reported with confusion and surprise that "the other Angela" said, "It's about time you realized what I did, you jerk." I explained to Angela that when people undergo intense trauma, the mind may try to wall off memories of the trauma, but it is still there and a part of the mind always knows that. As I talked, I drew a profile of a head and then wrote "Angela" and "other Angela" with circles around them inside the head. I marked the unwanted event memories (pain, stress) and unwanted emotions (anger, fear) that were held in the "Other Angela" and then created an extra thick wall "built up" around "Angela" to keep all of that out (Figure 6.1).

I explained that sometimes that part of the mind takes on a life of its own, and that is a perfectly natural way to cope with intense trauma. I reassured her that she was making outstanding progress by connecting with a part of herself that had been hidden, and that she should ignore the name-calling and work at trying hard to understand the feelings contained by the "Other Angela." I reassured her that if we did that, we could get to the bottom of her memory problems. Angela told me she was willing to do this, but insisted again that she, Angela, was *never* rude and that she did not like anything about the "Other Angela" no matter what I said. I asked her to keep an open mind and told her that even if she did not really appreciate the "Other Angela," I did appreciate her, knew she was essential, and thought she may be the key to really getting Angela to feel better again. I asked her during the next week to try to keep the channels of communication open between her and the "Other Angela."

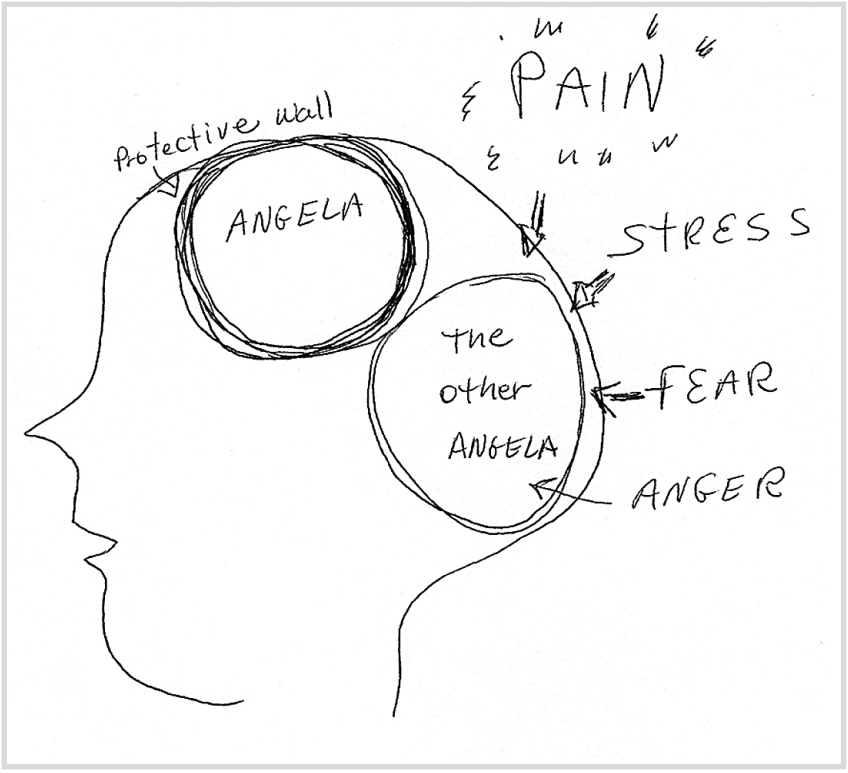


Figure 6.1 Angela's mind. (Used with permission.)

When working with adolescents with suspected dissociative disorders, there are several important interventions that I do in the early sessions, interventions that follow in a generally orderly way, as described by the acronym EDUCATE (Silberg, 2013).In this early session, one can see the use of interventions—"E": Educate, "D": Dissociation motivation, and "U": Understand what is hidden. The explanation of how the mind puts barriers around traumatic information sets the educational stage for helping the client see the importance of making connections between past trauma and current behavior. This connection is important for treatment to succeed. Validating the importance of the feelings of the 'Other Angela" and praising her for doing this work helps counter Angela's initial resistance to moving past the dissociative avoidance—these are Dissociation motivation interventions. To uncover a hidden dissociative state, it is important to align oneself with the teen's own motivations. In this case, her own rudeness to her mother did not really seem to upset her, but losing a friend was concerning, and

this was the motivation for her to dig deeper to uncover how her own behavior may have caused her friend to abandon her. To help her get in touch with the "Other Angela," I am engaging in the "U" stage set of interventions—Understanding what is hidden, and "C"—Claiming the hidden affect and accepting it as one's own. I do this through helping Angela tune in internally to thoughts, voices, or affects she has been trying to avoid and seeing that they have an important purpose.

When working with teenagers, I do not ask for "switches," or call out other parts of the self. There are several reasons why I will not do this but, instead, ask the client to make all internal connections himself or herself through introspection and focused intention. At its core, I believe that the dissociation that results in dramatic state shifts to cope with unprocessed affect is a pathological neurological process. This pathological dissociative switching had become a conditioned avoidance response to the arousal of affect for which the client is phobic. Neurobiological studies teach us that affect is the binding "glue" that helps an individual to achieve a sense of continuity of consciousness and identity (Damasio, 1999). I do not want, by my intervention, ever to reinforce that pathological "brain habit" of dissociating and avoiding affect. Asking the child or teen to switch into that other self might strengthen, rather than weaken, those pathological neurological pathways. The therapy for a dissociative teen ultimately must teach the client to become increasingly more self-sufficient and autonomous (Silberg, 2001, 2013; Silberg and Dallam, 2009). I am constantly looking for ways to empower the client to become more autonomous and self-sufficient, making internal connections to break down the walls of the dissociative barriers. In early sessions, I always explain dissociation to the client in a normalizing way, helping the client understand that this was the client's mind's natural way of coping with intense affect, and that it is understandable that the client coped in this way. I found that this "listening in" with focused attention and an attitude of gratefulness almost always produces results with teens, and often they feel very peaceful just from this initial exercise. I often use more formal gratefulness exercises such as "thank you notes" to solidify acceptance of the whole self, which I will describe in the next section. Even though I felt we were off to a good start in uncovering this hidden self-state, I wondered if there might be other parts of the self that remained hidden. Angela's motivation to begin the therapeutic process was a good prognostic sign, and suggested that she had mastered the early developmental tasks of achieving a secure attachment and a sense of basic safety. For clients with more complex trauma suffered over years of interpersonal violence, this motivation and readiness for therapy is much harder to achieve.

Angela came into the third session more eager to talk to me and fill me in on the fact that regular internal conversation had now begun between her and the "Other Angela." However, she told me, it was mostly argument, as the "Other Angela" used provocative language telling her that her mother was "a bitch" and her friend Stephanie was "a loser and a slut." She seemed amused by this intensity and colorful language she was hearing from the "Other Angela" and continued to insist to me that it was nothing like her. I praised her for her courage in listening to the "Other Angela" and used positive words to reframe the "Other Angela's" attitude, calling her "spunky" and a "straight shooter," someone who can call it like "it is," and wondered if she might not like to have some of those cool characteristics. As I modeled praise and acceptance of the "Other Angela," Angela's attitude about her seemed to relax as well. I told her that maybe the "Other Angela" would not be so angry if we could listen to her feelings and find out what she has coped with. I asked her to extend sympathy to the "Other Angela," telling her she is sorry for what she had to go through, and see what the "Other Angela" tells her. Angela closed her eyes and opened them in about two minutes; she seemed troubled and moved by what she had heard. The "Other Angela" told her she thought she was going to "die from pain." Angela further explained to me that the "Other Angela" had felt that horrible pain during her eighteen months' illness, and protected Angela from feeling it herself. Her anger, said Angela, was a result of having felt so much pain for so long and not having been appreciated. She added that the "Other Angela" is most angry at her mom and feels the pain is her mom's fault. In addition, Angela discovered that the "Other Angela" did not think Stephanie was a good friend, as she did not visit her or call her when she was in the hospital and did not even tell her about a birthday party that Angela was unable to go to due to her hospitalization. I empathized with Angela about how scared, helpless, and tortured the feelings inside her were during this difficult time. I asked her if she would be willing to write a thank you note to the "Other Angela" thanking her for what she did to help her cope. Angela wrote the following: "Dear Angela, Thank you for helping me with the pain. I don't need to be angry at anyone anymore, no one else is hurting me. I will tell you if I need you. Love, Angela." She told me that after she wrote the note, the "Other Angela" felt more relaxed than she had before, and promised her they would not argue as much in the coming week. She explained, however, that the "Other Angela" was still furious at her mother for sending her to an eating disorder unit six months ago, instead of a medical hospital at the recommendation of a psychiatrist, and for seeming to believe that the pain was psychological, rather than getting a consult from a more experienced physician at a tertiary medical center.

Pain, helplessness, and fear of death are some of the most traumatic experiences a child can endure. As stated by Martha Stout (2003: 53), "A traumatic event opens in the mind a corridor to the apprehension of our essential helplessness and the possibility of death." In Angela's case, her ongoing pain with no diagnosis enhanced Angela's feelings of helplessness and terror. Diseth (2006) did a series of studies of children who had endured a medical procedure involving a painful dilation of the anus. He discovered that dissociation was increased among children whose parents were in the room and assisted with the procedure, as these children felt betrayed by their parent, and identified the pain as being caused by the parent. In this case, Angela's dissociation is facilitated by her feelings of betrayal by her mother, whom she perceived as ignoring her pleas for help. This anger at her mother is sequestered in the dissociative state of the "Other Angela," who also served to protect Angela's consciousness from the experience of the intense pain. Research and clinical speculation suggests that at the root of many dissociative presentations there is some form of conflict-filled attachment (Carlson, 1998; Liotti, 2009; Schore, 2009). In this case, Angela's secure attachment to her mother is threatened by her feelings of anger and betrayal that her mother could not assist her with resolution of the pain. As the "Other Angela" expressed, "if her mother really cared she would have found the right doctor sooner." Because the resolution of attachment binds is an important component in the remediation of dissociative symptomatology (Silberg, 2004, 2013), it became clear that I would need to involve the mother in the treatment process over time. In accordance with the EDUCATE acronym, the "A" phase involves strengthening Attachment and learning to modulate Arousal and Affect in the context of the important relationship with her mother.

It is, of course, important to assess how well a parent may be able to handle the interventions involved in family work. This assessment of the family functioning begins immediately when history is taken at the first session. Does the parent tend to blame the child overly? Is the parent unduly defensive, denying any responsibility? Does the parent seem evasive about family issues, and hostile in describing the child and the child's behavior?

In this case, I observed that Mrs. Stein had a good combination of introspection, guilt about any role she might have played in the current symptoms, and eagerness to follow therapeutic advice. All of these were good signs that family work might be able to progress as needed. Sometimes, I might refer the parent for individual therapy with another provider if they are not able to participate in the kind of family work that is required.

Unfortunately, the previous session led to an increase in the rude, defiant behaviors that had brought Angela into treatment. She was leaving the dinner table stating the dinner "sucked," disobeying established curfews, and "forgetting" to do her homework. Her mother came to the next session asking to speak with me, and recounted some of the events of the last week. Plaintively, she asked, "When will I get my Angela back?" I explained that those were not the right questions, as development always went forward and not backward. Our aim, I explained, was not to get the old Angela back, but to get a healthy new Angela who incorporated all of the feelings that Angela harbored. I explained that her view of her mother's betrayal was becoming more important, and told the mother to bear with Angela's current changes and defiance, as they signified that Angela was getting increasingly safer to express hidden feelings. In fact, when I talked to Angela, she told me she was beginning to have more memory for the behaviors of the last week, and told me about them with a bemused expression, as if talking about the behavior of a younger sister whose antics she could secretly enjoy without taking responsibility. She told me she really did not want to do her homework, as it was "stupid baby work" and "beneath" her. She had taken a temporary leave from her accelerated curriculum and found the work in the new classes too easy. She left dinner because her mother encouraging her to eat was "getting old," and reminded her of the times when her mother and doctors thought that her medical issues were an eating disorder and she was put on a strict eating regimen. Angela had gotten better at noticing the moments that triggered her changes in behavior and affect, and was proud to show off her new ability to connect affect and behavior, and relate it to the past. In fact, currently, Angela was gaining weight and even had a little more color in her face. She took off her wig and showed me with pride that some small wisps of blonde hair were returning to her head. Angela was less angry at the "Other Angela" in this session, and although she was still not willing to consider the "Other Angela" herself, she was more tolerant of her behaviors. She told me she had a conversation with the "Other Angela" and decided it was okay to reconcile with Stephanie, had called her, and they had plans to go out this weekend. Angela was successfully working on inner dialogue and coconsciousness, and was beginning to understand that she needed to acknowledge the real feelings she harbored in the dissociative state she called the "Other Angela" in order to move forward with her life. In the next few sessions, we continued to work on her exploring the feelings of the "Other Angela" about everyday things, school, her mother, and her friends, and Angela was surprised to discover that there were many insights the "Other Angela" had that were helpful to her. Instead of the feelings automatically leading to acting out in ways that surprised her and embarrassed her, Angela realized that listening to the "Other Angela" had its benefits. Angela felt stronger over this period and resumed one of her

favorite activities, dance class, which also seemed to help her express some of her increasing affective energy.

As Angela became more comfortable internally interacting with the "Other Angela," it became important to assess whether there were other hidden parts for which her awareness was blocked. This was assessed repeatedly by asking her to ask the "Other Angela" internally whether there were some other hidden parts that had important information. I also continued to assess if there were events for which memory was blocked that the "Other Angela" could not account for. In addition, I inquired about evidence of any regressed or babyish functioning, or uncharacteristic behavior, observed by others. All of these inquiries yielded negative responses. As far as Angela and the "Other Angela" could report, there were no other hidden self-states in this dissociative presentation.

In helping a teenager feel more comfortable with acknowledging an inner dissociative state, it is helpful at first to focus on feelings and reactions to the current environment that are perceived as emanating from the dissociative state. This is less frightening than looking at past memories and experiences. In this situation, Angela was finding that the "Other Angela" was an important resource for helping her evaluate her friends more accurately, and helping her tune in to justifiable anger about the ways her mother treated her that felt invalidating. This bridging of understanding between Angela and her dissociated self helped her avoid the past triggers (the "T" stage of EDUCATE: Triggers and trauma) and was important groundwork for delving deeper into the pain.

It is rare for a dissociative presentation to have only one split-off self-state, in my experience, but I have observed this in some other dissociative teens, particularly those who have a basically secure attachment to a primary attachment figure.

A Turning Point

After about four months of treatment, Angela was feeling better physically and emotionally. She had gained some weight, color returned to her face, and her hair was growing back nicely. She had reentered one of her challenging courses and was gratified to be able to keep up with the work without memory problems. She had reconciled with her friends, and they were no longer reporting to her about out-of-character rudeness. Instead, she was better at telling them what was on her mind if she did not like a plan they had come up with. However, she continued to be rude to her mother, and yelled at her mother for "dumb things" she thought her mother said or did. Most of the time now, she felt it was she, Angela, who was

saying these things, but at times, when curse words were used, she felt it was the "Other Angela." We began to explore what she and the "Other Angela" might need in order to deal with the pain that had been endured for so long. I asked Angela, along with the "Other Angela," to tell me in detail what the pain she had endured felt like. Angela returned to her monosyllabic presentation at this point, stating it was bad, it hurt. I asked her if the "Other Angela" had more words to describe it. Again, she said, the "Other Angela" told her only that "it hurt." I suggested to Angela that we could probably fill a whole page with words that described her pain, and that doing so might help the "Other Angela" feel better. Angela seemed skeptical and said there were no other words. I asked her if she knew what a thesaurus was, and she said she had used it for school. I had her come to my desk and use the thesaurus program on Microsoft Word to identify all the words she could that would describe what she experienced during the time of her intense pain. The "Other Angela" and she were to work together on this assignment.

At first, she was hesitant and unsure how to proceed, but I showed her how finding one word could yield six more equivalents, and then picking one of those words, could lead to a whole new list. Through this process, she generated a list of twenty-five words that she wrote in crayon across construction paper which included, "grinding, twisting, screaming, painful, agony, torture, binding." I asked her to stop the exercise when she believed she had successfully captured how the pain really felt.

I asked her then to illustrate the page using crayon colors. She chose red, orange, and black, which she colored in large, sweeping swirls over the top of the words, and stopped when the whole page was covered. The words could still be seen through the swirling covers. She seemed proud of her creation and said very little as she worked on this. I asked her if she was ready to let her mother know once and for all the way she really felt during this time. I asked her to check with the "Other Angela," who told her, "Your mother doesn't really care." I encouraged her to talk the "Other Angela" into giving her mother a chance to hear about these feelings and then judge whether she cared or not. I knew from my talking with the mother that having Angela open up to her more would be gratifying and that Mrs. Stein was emotionally mature enough to handle hearing about this in a way that could soothe Angela.

Angela agreed to try. We invited Mrs. Stein into the room, and I asked Angela to tell her slowly using the words on the page how the pain felt. Angela did this, slowly pronouncing each word and looking straight into her mother's eyes. I encouraged the mother to listen at first, and not respond. As Angela spoke, her mother's eyes filled with tears, which ran down her face as Angela pronounced each one of the pain words. Angela wanted to stop when she saw her mother crying, and I told her she could not stop, as it was time that her mother cried for her pain, and that is what

mothers were supposed to do. As Angela read the list, the mother continued to silently weep. After the reading of the list of pain words was finished, I helped Mrs. Stein express sorrow and apology for not understanding what her daughter was going through, for believing the psychiatrists who told her it was simply emotional pain, and for not getting help for her more quickly. I helped her draft a solemn promise that if the pain or any similar pain ever returned, she would work quickly and diligently to get Angela to the right hospital. She signed a paper with this solemn promise on it. Angela left my office saying very little.

These interventions begin the "T" phase of the EDUCATE acronym, the processing of traumatic memory, best accomplished in the presence of the primary attachment figure, in this case, Angela's mother. With Angela's affective life so blocked, even thinking of the words to describe her feelings of pain became a huge barrier. I had Angela use the thesaurus, as I knew she liked to do schoolwork, and this made the assignment feel more familiar. Angela was not a talkative girl apart from her dissociative avoidance, and it was often hard to get Angela to talk at all. The process of finding words for her pain would be a way to allow the two parts of her to work together in sharing an affective experience, part of the "C" set of interventions—Claiming as one's own the hidden aspects of self—in the EDUCATE model. It was also a way to help her connect emotionally to her mother, a technique from the "A" phase of the model—Arousal modulation/Affect regulation/Attachment. Often in therapy, techniques from the various phases are intertwined. The observation that lack of soothing may be the genesis of dissociative etiology was first put forth by Kluft (1985). Kluft observed that the experience of trauma without the opportunity to have that trauma soothed in a caregiving relationship leaves the child with no other options but to develop dissociated feeling states, and to find soothing within imaginary characters of the child's own creation. Angela's perception that her mother had sided with the psychiatrists, who thought her pain was psychological, deprived her of that central soothing experience. Unable to share the traumatic experience and achieve validation from a significant attachment object, Angela coped through dissociation. It should be clarified that I really do not blame the mother, who did everything she thought was right in providing appropriate care for her daughter. The point is not whether Mrs. Stein objectively did the right thing but how Angela, and the sequestered state of the "Other Angela," felt. The apology helps soothe this sense of deprivation and does not mean that the parent really is acknowledging that he or she is a "terrible or neglectful parent." Children believe that a mother should be the answer to all problems. It is important to clarify with a parent before pursuing a treatment like this that the therapist

does not blame the parent, and justifying their actions to the child will not be helpful, only listening and validating the feelings will be. The mutual eye gaze that took place during this therapeutic exercise has the potential to change the neural circuitry of the brain, as demonstrated in the work of Schore (2003).

In the next session, Angela looked different, with a lighter expression and more spontaneity in her step and speech. "How are you doing?" I asked her. "It worked," she said. I asked her what she meant by that, and she explained to me that after the last session, "Other Angela" told her she had finally been understood and did not need to be separate any longer. She said she felt a weird feeling, and then "Other Angela" "kind of disappeared," she said. Having her mother listen to that list of words had helped "Other Angela" feel listened to and validated, and she no longer needed to be separated. The attachment rupture of the dissociated state was repaired with this exercise, and Angela felt willing to try to trust her mother again.

Angela's life started to return to normal and become more typical of a 14-year-old entering ninth grade. She and her mother fought occasionally, but not with the out-of-character rude style we had seen earlier. Angela's memory problems resolved, and she switched back to a more complete accelerated curriculum. Her friends accepted her, and her functioning appeared to be restored. We agreed to stay in touch as needed, and Angela returned to her regular therapist, which was more convenient for her as she lived in a neighboring town. Little did I know that the mother's solemn promise to get her immediate help was to be tested six months later.

The process by which children and adolescents achieve a sense of internal integration is not well understood. Spontaneous integrations such as Angela described are reported in the literature (Shirar, 1996; Waters and Silberg, 1998), particularly during a treatment geared to the expression of hidden affect states. However this process comes about, it usually is associated with observable differences in the affective presentation of the youngster, which is noted by those who interact most frequently with the youngster. Angela's memory problems at school appeared to be a carryover from her dissociative style of coping. A mind prone to lapses in memory may cause difficulties in consistent memory for schoolwork. Specifically, when reading books, content that had any association to things Angela was trying to block from awareness got blocked as well. As the dissociated affect was integrated, this school difficulty remitted as well. It seemed we had reached the "E" stage of therapy, the Ending stage, where gains are consolidated and the young person returns to his or her normal developmental trajectory.

> But life is change, and with a dissociative youngster new developmental challenges can result in setbacks, or in new areas of traumatic content to explore.

The Second Bout of Pain

Six months after this phase of therapy was over, Mrs. Stein called me in a panic. "Remember the solemn promise I made in your office?" she inquired. "Now is the time to make good on it. Angela is in severe pain again." I had also promised Angela and Mrs. Stein that, should this happen again, I would find her referrals through a local tertiary medical center to have her evaluated rapidly. Mrs. Stein reported that Angela was writhing in severe pain, that a trip to the emergency room had resulted in a brief admission, and the hospital was recommending psychiatric inpatient care. I thanked her for calling me promptly and facilitated an emergency appointment with a local pediatric surgeon. I reassured the mother that she was right, that it was too soon to attribute this to psychiatric reasons, and advised her that, given Angela's past history of requiring surgical intervention, a surgeon should see her expeditiously. She explained that her previous surgeon was seeking another opinion before any further surgical intervention. The new surgeon who examined her sent her for immediate admission due to her level of pain. A medical evaluation revealed cholecystitis, a severely inflamed gallbladder, which was promptly removed. Angela came to visit me two weeks after surgery. I asked her if the "Other Angela" had returned during this frightening return of pain, and she responded "no." She told me that her mother's response to her and the prompt actions of the doctors led her to feel cared for and responded to, and the "Other Angela" had not reemerged. She resumed her active life, became involved in a dance company, took an enriched college preparatory curriculum, and was looking like a happy and thriving teenager as we parted company again for the second time.

The Return of the "Other Angela" and a Surprise Disclosure

Eighteen months later, Mrs. Stein called me, stating that Angela was asking to see me. As far as she knew things were going well, but Angela continued to have intermittent pain, not as severe as it had been before. They were coping by having Angela take a few days off, and then usually the pain subsided and she resumed her normal activities. Although she fell behind in her schoolwork each time the pain emerged, the school was flexible with her and gave her time to complete assignments. A studious girl, she managed to catch up with her work every time she fell behind.

Angela, now 16, looked beautiful when she returned to my care. She wore her hair short, had her face made up attractively, and had grown an inch or two. She told me she had a boyfriend, her first one, and they got along great. She said she wanted to see me because she was hearing from the "Other Angela" again and did not know why or what to do about it. She had not told her mother about this, but the "Other Angela" was saying rude things to her boyfriend, and later she would have to apologize. She did not understand why this was happening or why the "Other Angela" had returned, or why the "Other Angela" had an issue with her boyfriend. She was hoping that I could help her figure it out. She knew she was supposed to try to talk to the "Other Angela" but expressed fear about doing that without my support.

After getting an update about her school and activities, it was clear to me that Angela was pushing herself too hard—she was overscheduled and overstressed. Between dance rehearsals, school projects, and her social life, Angela had no down time. I wondered if the pain was a psychosomatic protection to give her some breaks from the intensity. Again, I asked her to listen in to what the "Other Angela" had to say, and extend understanding and compassion for her viewpoint. At first, this was difficult for Angela, but eventually she remembered the techniques for focusing her attention inwardly, and she learned from the "Other Angela" that her schoolwork was very hard, that her boyfriend was too demanding on her time, and that she needed her now to keep her from driving herself too hard. Angela did not agree and said there was nothing she could give up, that everything was equally important and she would just have to juggle all of it. I reminded her that the "Other Angela" contained wisdom that we could not ignore, and that she needed to heed the internal advice she was getting and find ways to ease her schedule. She agreed on an initial plan to drop one of her hard courses that was an elective that would not affect her graduation requirements. This would allow her to have a study period to do her homework, as she rarely had time in the evenings. The school and family agreed to this initial intervention, and I was pleased that Angela was again listening to the feelings of the "Other Angela" and responding, as this would help her eventually be able to integrate whatever feelings and memories were remaining outside of her awareness.

I was unsure why the "Other Angela" had returned, but I wanted, first, to empower Angela to listen to her again in areas that were not too loaded emotionally, so that she might be more accepting of any more serious issues that might emerge. Working with dissociative teens, one must always be sensitive to issues of sexual exploitation, and I was particularly concerned that Angela might be vulnerable to this, or have been a victim. I was curious about the "Other Angela's" intense antipathy toward the boyfriend and remained alert for signs of abuse. By empowering Angela once again to

> embrace the thoughts and feelings contained in the "Other Angela," I hoped I would set the stage for any important further disclosures. I was also listening for transitional moments, when dissociative coping appeared her only choice and the "other Angela" was activated.

In subsequent sessions, Angela began to tell me that the "Other Angela" was telling her she had a secret that she needed to reveal. Angela expressed fear that the "Other Angela" feared something terrible would happen to her if she told, and I continued to reassure her that there were no secrets so terrible that we could not together find a way to handle them. I had helped her listen to the "Other Angela" about limiting her time with her boyfriend to one night a week, and she seemed relieved about this. I asked her what she thought it would take to be able to reassure the "Other Angela" enough to let her secret be revealed. After about five sessions, Angela told me it was time to let the "Other Angela" tell her the secret. I helped her relax and reassured her that we would handle it together, and that she was being very brave to be willing to listen to something so difficult that the "Other Angela" had felt the need to keep it a secret. Relaxation techniques for Angela included practicing slow rhythmic breathing and picturing herself walking on a path in the woods. Once, she was calm enough, I asked her if she preferred to let the "Other Angela" write things down on a pad of paper, rather than talk to her. This technique had been used by us in the past to garner important information, and Angela agreed that the "Other Angela" could communicate with us by letter. I handed her a pad, curious about what would emerge. Angela scribbled in a child-like handwriting, "It happened on vacation. I couldn't scream. I couldn't tell my mother."

I asked Angela if she knew what that meant, and she said she really did not know. I asked her to think about a year when she thought there might have been a vacation that was troubling. She said the only one that came to mind was a cruise vacation she had taken with another family when she was 8 years old. She did not remember anything bad happening on that trip but was convinced that, if there was a trip where there was a problem, it would be that trip. I asked if we could ask her mother to come in to tell us more about that vacation. She agreed, and without asking her mother to tell us why, we asked her to share with us about the vacation they had taken when Angela was 8 years old. The mother shared mostly positive memories about this vacation, describing whom they had been with, and added that it was on this vacation that the older brother had made a friend who had later introduced him to drugs, and they were sorry about that outcome. After the mother left the room, Angela's face looked even more pale than usual. "I remember," she whispered, in a barely audible voice. Over the next few sessions, Angela recounted with the help of the "Other Angela" a horrific story of sexual abuse that emerged with scribbled

sentences and flashes of memory seen in pictures in her mind. She remembered being sexually assaulted by a man on the cruise ship who had masqueraded as one of the cruise staff. She had visited the children's game room, which was heavily staffed, and she recalled a man coming up to her telling her he had special games for her in another room. Unlike the other staff, he was not wearing a name tag. She went with him willingly, and he locked her in a cabin on the ship where she was sexually assaulted. She remembers that he threatened he would throw her mother off the ship if she told, and she recalls pretending with all of her might that it had not happened, until she basically forgot it by that evening on the cruise ship. She believes that the "Other Angela" emerged during the sexual assault as a protective force, a way to help her cope with pain, and a way to keep important secrets. This "Other Angela" built up a severe antagonism toward Angela's mother for not figuring out what had happened, and for her isolation and pain in having to bear this secret knowledge alone. The thought of sexual activity with her new boyfriend had frightened the "Other Angela," who worried it would be painful. In addition, the "Other Angela" did not think it was safe to trust boys or men in general, and this relationship had been destabilizing to her.

We had explored any history of sexual abuse earlier, which had been believably denied by Angela and "Other Angela." In addition, careful interviewing of the parents revealed no suspicions of a history of abuse, or questionable times with babysitters or other extended family members. The medical trauma had appeared sufficient to explain the level of symptomatology seen before, and the resulting treatment had been effective.

However, Angela's experience of sexual abuse had most likely been the background for the development of her dissociative coping style. The dissociative self-state of the "Other Angela," already a mental receptacle for unprocessed pain and fear, was readily available when the new trauma of the undiagnosed pain presented itself. Angela had learned an automatic pattern of affect avoidance which she relied on in this new situation where she experienced anger and hopelessness in response to her medical issues. There appeared to be an integration of the "Other Angela" after the pain was dealt with, but it reemerged as there was unprocessed emotion related to the sexual trauma that needed to be uncovered and explored. The trigger of a romantic relationship served as a stimulus for the "Other Angela" to return. The threat that her mother would be thrown off the boat, a very realistic worry for an 8-year-old, added to the underlying rage she began to develop toward her mother, whom she felt she had "protected," and yet her mother had not protected her. During this period of intervention, using techniques that regulated Arousal and Affect became an important part of the work (the "A" phase of interventions).

Resolution of the Sexual Trauma and Reintegration of the "Other Angela"

Once this secret was revealed, treatment progressed rapidly. Over the next several sessions, Angela became familiar with the thoughts and emotions she experienced in the sexual assault on the cruise, to which the "Other Angela" gave her access slowly. She agreed to have a meeting with her mother where she shared the experience; her mother, as she had been trained to do earlier, listened, sympathized, validated her feelings, and apologized for not knowing. Angela opted to tell her boyfriend about the experience, and he turned out to be a compassionate and sensitive young man, and told her that they should be cautious about any sexual activity due to this history, which was very relieving to Angela. Angela's concerns about the sexual abuse issues diminished, but the "Other Angela" remained, handling her conflicts about the ongoing intermittent pain, and her high need for achievement.

Angela continued to have bouts of abdominal pain and lethargy but continued to schedule herself with multiple dance rehearsals and extra school projects. Often, the "Other Angela" would tell her she needed to miss a dance rehearsal, or get an extension on a project. This conflict between her high need for achievement and physical tiredness and pain finally led to a school crisis.

The principal at school received a note in a child-like script that asked the principal to excuse "Angelina" from dance class. (No one at school called her Angelina, and this name was unfamiliar to them.) In addition, the note went into great detail about a pain in her back and side, and how she could not dance because of this. The note was signed with her father's name. The principal immediately recognized that this was a "forgery," but knowing that Angela had some psychological issues, the principal called the family and myself to ask how to proceed. I asked the school to fax me the note before our next session.

I showed the note to Angela and asked her if she remembered writing it, or having given it to the principal. She was mortified and had no memory of this. I asked her to ask the "Other Angela" if she could fill in the memory of this event. Angela learned that she had been feeling trapped by having to go to this dance class, and this trap led to her automatic affect avoidance and transition moment to a dissociative coping approach. As she was tired, sick and needed a break, the "Other Angela" decided to take matters into her own hands to help her solve the problem. Angelina was apparently the "Other Angela's" nickname for Angela, something I had not heard before. I asked Angela to have a talk with the "Other Angela" about why it was not appropriate to write a note such as this. Angela wrote the following letter to the "Other Angela": "In this world you cannot forge somebody else's signature even if it seems like a good idea. It's against school rules and against the law. It can get me in a lot of trouble and can get people

not to trust me or what I have to say. In the future I will listen to what you have to say when I am pushing myself too hard. And I will deal with it in a safe way."

This was a watershed event in Angela's treatment. She finally realized the risk to herself of pushing herself so hard that only the "Other Angela" could rescue her from herself. Her family asked me if they should punish her, and I advised that they should have a consequence as she had forged a signature. They opted for a week-long grounding, which was mild given the infraction. Angela, at first, was incensed that she was being punished for something she perceived she did not do. However, this punishment illustrated to her in a concrete way that she would have to be responsible for the behavior of the "Other Angela," whether or not she agreed with it. The consequence of embarrassment in front of the administration of the school and consequence given by her parents successfully conveyed to her the importance of continuing to pay attention to the "Other Angela's" input.

> It is hard for therapists in these situations to help families come up with realistic consequences that don't feel overly punitive. Certainly, a child who seems to be developing an antisocial behavior pattern needs to see clear consequences. However, in a case such as this, where Angela's behavior was a source of humiliation and her conscience was very developed, an overly punitive approach to the behavior of writing the note did not seem appropriate.

Treatment proceeded rapidly after this event, with Angela successfully making better choices about how to structure her work schedule and dance schedule. She was treated by an allergist who finally diagnosed her continued intermittent pain as eosinophilic gastroenteritis, a food allergy known to cause severe symptoms. A change in diet eliminated all pain entirely. Angela continued in treatment for several more months, and slowly the "Other Angela" became a distant memory. At her last session, Angela told me that the "Other Angela" was no longer a factor, and that they had worked together well enough that the "Other Angela" realized that Angela could take over all the work herself. She was successfully managing her difficult eleventh-grade curriculum and performing in a dance troupe, but she had cut out the dance classes at school that added too much stress to her day. She felt she had successfully worked through the issues related to her sexual trauma and began dating a new boyfriend with whom she said she felt completely comfortable. She promised to keep in touch should further problems develop.

I heard from Angela six months later, as she asked me to fill out a survey for her junior project on how medical professionals relate to pediatric

patients. She told me she hoped to go to medical school and work as a pediatrician, as she felt that doctors did not always understand how to listen to children and their symptoms. Follow-up indicates that Angela is studying neuroscience in a demanding college program and has had no further dissociative regressions. She has described a strong desire to help other children who have dealt with dissociation and early trauma, eager to use her experiences to help others. This altruistic impulse is common in young adults with early histories of dissociation who have successfully resolved their traumatic past (Silberg, 2013).

Angela's complex course of treatment shows how treatment evolves over time with many complex overlapping factors. She had a confusing medical history with several medical conditions that took time to diagnose. This medical trauma was overlaid on a sexual assault trauma that had been buried for many years. Although the initial course of treatment did not fully resolve the dissociation, the groundwork had been laid for solving further dissociative problems as they emerged. The work proceeded along the outlined process from the EDUCATE model, beginning with education about dissociation ("E"), and helping her understand the hidden "Other Angela" ("U") and learn to claim those feelings as her own ("C"). Then work proceeded on the important dimension of attachment ("A") to her mother and modulating arousal and affect, while working on identifying triggers ("T") to affect avoidance and processing traumatic content ("T"), with the final stage of solidifying her gains and moving on with an age-appropriate life trajectory at the ending stage of treatment ("E"). It should be noted that the work with the mother at opportune moments throughout the treatment allowed Angela to process her anger and feelings of betrayal so that the attachment relationship could be solidified. The therapist's attitude modeling acceptance for the wisdom of her dissociated part allowed her to appreciate the importance of the hidden affects she had dissociated. When she acted out inappropriately at school by forging a note, a commonsense approach with firm boundaries made possible her acceptance of the feelings of the dissociated part. She learned that she had to find an integrated way to manage her life with respect for all of her competing feelings. Issues emerged in treatment related to her brother and the time the family spent focusing on his issues, which often led Angela to feel ignored. The activation in her brother's issues happened directly after the cruise vacation, making it even harder for Angela to share her story.

This is an atypical case of dissociation that may be seen as dissociative disorder not elsewhere classified (DDNEC). Although there were some features of dissociative identity disorder (DID), Angela had only one identifiable dissociated personality, and her trauma was not the complex

interpersonal trauma most often seen in full cases of DID (Putnam, 1997). Unlike a patient with a full-blown DID presentation, Angela could be treated relatively quickly and returned to relatively normal functioning during each successive therapeutic episode. Angela showed the transient use of dissociative coping defenses during stressful periods, but had generally intact functioning in many areas and did not display the global impairment seen in DID with affect regulation, self-harm, and significant depression. The case also illustrates how the Affect Avoidance Theory can be applied to the analysis of a teenage girl with multiple forms of early trauma and how the EDUCATE acronym can help organize successful treatment interventions (Silberg, 2013).

Editor's Comment

Joyanna Silberg describes a high-functioning adolescent who presents with ill health, flat affect, and rude behaviors for which the adolescent has no memory. Although Angela does, in time, recognize an "alternate self-state," there is not a complex internal system such as was seen with Dalma, Jason, and Ryan. Angela clearly experiences pain and does not describe watching herself from the outside. She thus does not have a depersonalization disorder as seen with Ryan. She is well aware of where she is and how old she is, and thus does not experience derealization as Jason did. Silberg identifies Angela as having a DDNEC (American Psychiatric Association, 2013).

Silberg describes how the early secure attachment between Angela and her mother developed chinks in it when mother was not able (first, because of lack of knowing and, later, because of lack of medical follow-up) to provide soothing and reassurance of safety. Without the soothing and safety, Angela was not able to work through and incorporate her trauma experiences into her self-story. Describing this case through the lens of the Affect Avoidance Theory of dissociation (Silberg, 2013), Silberg highlights Angela's avoidance of the negative affect related to medical pain (e.g., fear/terror of death); avoidance of the huge negative affect related to the sexual assault (e.g., shame/humiliation related to the assault on her body; anger/rage for her mother's lack of protection), and avoidance of the negative affect related to recognizing that she cannot do everything (e.g., shame of not being perfect). Similar to Marks, Waters, and Wieland, Silberg uses mother's help during the therapy but in a very different manner. As was appropriate, given Angela's age, Mother was not part of the ongoing work, but she did assist during the therapy by listening to Angela's anger and later her story, by acknowledging what had happened, by asking Angela to forgive her, and by promising to be more attentive and get help more quickly in the future.

Where the therapists working with younger children used drawings to provide a bridge to verbal expression, Silberg uses academic work (the thesaurus) to engage Angela's energy and also to deepen her conscious awareness of the emotional experience, and then used coloring as a bridge to her nonverbal, unconscious affect experience (right hemisphere functioning, Schore, 2012). These techniques would help link or develop neuronal pathways that provide more integrative functioning. Silberg models (possibly stimulating mirror neurons for positive action) not only appropriate affect expression, but also respectful appreciation for the "Other Angela's" holding of anger and wisdom. Throughout the therapy, Silberg encourages Angela to be curious and talks in terms of trying experiments to find out what they can learn.

The reemergence of the "Other Angela" (what Silberg would refer to as a transitional moment) reminds us of the reemergence of the withdrawn Dalma in the second stage of Baita's therapy. With both incidents, the therapists look for a trigger: for Angela, it was the relationship with a boyfriend that could imply sexual interaction; for Dalma, it was the relationship with her mother who was unable to protect. These triggers alerted Baita and Silberg that more work needed to be done. Silberg assists Angela and "Other Angela" in doing the detective work.

Silberg's emphasis on asking Angela to inquire within about what was happening, rather than asking to speak directly to the "Other Angela," should be noted. It can be hypothesized that this emphasis on internal communication, away from switching, helps the individual build neuronal connections. The neuronal pathways "holding" affect avoidant responses represented by switching are weakened. Similar to Waters, Silberg is concerned about the existence of "hidden parts." Unlike Ryan, however, no other parts appeared. What did appear was an earlier trauma.

Silberg (2013) has closely linked her understanding of dissociation to recent research identifying the dysfunctional neurological shifts that occur in the brains of children who experience maltreatment. She highlights the relationship between stress and the ability to remember what has happened. As Angela's stress (whether it is the pressure of unexpressed negative affect, the pressure to succeed, or the pressure to keep away awareness of the abuse trauma) increases, memory capability declines (see discussion in Chapter 1 on effects of stress on HPA, and pre-frontal lobe and hippocampal functioning) and the presence of the dissociative "Other Angela" increases. As these stresses are addressed and lessened, the neurophysiological system calms and ability to remember (better integrative functioning) increases. Her efforts to model expression of strong affect and to have Angela listen inside remind us of Putnam's (1997) emphasis on developing linkages between behavioral states. While Angela as a 14-year-old daughter does not feel uncomfortable with her behavior toward her mother, and thus has no motivation to change, Silberg is able to appeal to Angela's "friend ego-state" (Watkins and Watkins, 1979) which does

not want to be nasty to her friends. Similar to the treatment process described by structural dissociation theorists (van der Hart et al., 2006), Silberg emphasizes the need to search for those reactions and memories that have been pushed away (for which the child has become phobic). Angela clearly did not experience early disorganized attachment (Liotti, 2009), but her experience of her mother having betrayed her by not understanding her pain, and by not knowing about the earlier sexual abuse even without being told, would have caused a contradictory sense of mother similar to what happens with disorganized attachment. This dual sense of mother could possibly create a dual sense of self and, thus, a vulnerability to dissociation.

Silberg provides us with a description of therapy that is based on the affect avoidance model of dissociation and that follows the EDUCATE acronym: Educate, Dissociation motivation, Understand what is hidden, Claim hidden aspects of self, Arousal modulation/Affect regulation/ Attachment, Triggers and Trauma, Ending. Her description of her work with Angela presents more than dissociation-focused therapy, she describes the need to engage and motivate adolescents, the importance of including family work when relevant, and a careful, non-intrusive way to pursue dissociated trauma.

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7 Leroy (7 Years Old)—"It is Almost Like He is Two Children"

Working with a Dissociative Child in a School Setting

Na'ama Yehuda

Approaching Mrs. Tibo's first-grade special-education class is akin to closing in on a thundering waterfall—the sounds assault you long before you see the sights. The racket today is louder than usual, however. Alarmed, I cover the distance to the classroom with wide steps, and taking a deep breath to make sure I am fully present, I open the classroom's door. Huddled in a corner at the end of the room, a boy is holding a chair, seat to chest, four legs aimed at the teacher. He is yelling: "I gonna' beat you up, I gonna' beat you up!" It is Leroy, one of three children on my caseload from this class. Ms. Linda, the teacher's assistant, attempts to restore order by incrementally raising the volume of her own voice. Mrs. Tibo, en route for the chair with her own voice reaching foghorn proportions, threatens to call Leroy's grandmother. This only seems to have the effect of increasing the zealous thrusts of the chair in her direction.

Seven-year-old Leroy is of average height and medium build, with long eyelashes framing haunting dark eyes, shiny brown skin, and a body that is pure muscle. I have been seeing him for the last three weeks, ever since I was assigned as a speech-language-pathology consultant to this Harlem elementary public school. The agency I work with fills up holes in staffing that the Department of Education is not able to fill. This means that almost every year I get assigned to a different school.

According to his Individual Education Program (IEP), Leroy has speech and language delays and is mandated for twice-weekly 30-minute sessions in a group of two. I have been seeing him with C.K., another child from this class, partially because they know each other but mostly because this combination proved to be the least combustible.

Working as a consultant to the New York City Department of Education, I am often in schools in Harlem or the more difficult (read: impoverished) areas

of the Bronx, where the proportion of children needing help is in direct opposition to the number of resources available to them.

All too often, these children's speech and language needs are a result of a combination of poverty-limiting life experiences and environments, and a staggering prevalence of early traumatic experiences: homelessness, neglect, domestic violence, as well as direct trauma, abandonment, and abuse. With scant support in the presence of chaotic overwhelm, children end up having to close off some parts of their experiences, and to distance themselves from the emotions and events. They put up protective walls between themselves and others, and shut down inwardly, resulting in another kind of communicative poverty.

These children frequently need to learn how to use language socially, how to narrate, inform, and explain. At times, this requires they be seen in small, supervised groups before carrying over new skills to unsupervised interactions. In Leroy's case, with no opening for an individual session and given his social language issues, a group of two was an acceptable compromise, and I take him by himself whenever possible.

Leroy's file reports reduced expressive and receptive vocabulary, dismal attention span, difficulty following directions, and overall insufficient academic performance. His language-learning problems surpass the environmental delay often present in inner-city children. He shows distinct difficulty in identifying emotions in pictures or stories, and his replies tend to be unusual, even unsettling. When I showed him a picture of a boy with a broken bike and asked how he thought the boy was feeling, he said, "Happy." When I asked why or inquired what he thought the boy would do next, he just stared uncomprehending. Looking at a girl's birthday party picture he said, "She mad," but was unable to say anything more about what he meant or why a smiling girl with presents galore would seem to him to be angry. Internal sensations, also, are a foreign language to Leroy. He could not name or even seem to recognize hunger, pain, fatigue, or thirst. Although he rattles off names of rap stars and lyrics—foul language and all—he struggles with identifying things such as the steering wheel on a car or the wings on an airplane. He lacks adjectives such as dirty, full, empty, heavy, or short. His descriptions and judgments are limited to "good" and "bad": a full cup is "good" and an empty one is "bad"; a clean shirt is "good" and a dirty shirt is "bad." Leroy's communication is not only delayed but seems to follow a different vector than that of "standard" delays.

Although there is relatively little research about it to date, children with emotional issues (especially those with maltreatment/trauma histories) tend to show language delays that do not follow the presentation of "usual"

language disorders. They often have difficulty with emotive and state language, sequence, cause–effect, and narrative; and may show increased difficulty with personal narrative compared with general narrative. Their language profile can be inconsistent, and their abilities may fluctuate from session to session; sometimes even within the same session. They can appear very literal, have short attention spans and, as a group, are more likely to be in Special Education than their peers (Cohen, 2001; Putnam, 1993, 1997; Yehuda, 2004, 2005).

Even though trauma history is not clearly defined in Leroy's file, he has indicators for difficulties with emotional regulation, as well as some posttraumatic and dissociative tendencies. Observing Leroy in the classroom and speaking with his teachers makes it evident that he is an aggressive and explosive child who attacks other students with malicious force at the slightest (and sometimes no apparent) provocation. Sailing through the air with the agility of a trapeze acrobat, he would punch a class member, or toss a table and its contents to the side, and then routinely and fumingly deny the very action and attack again, enraged by the accusation. Leroy stares a lot, becoming unresponsive to his name. He also runs away from class, hits his teachers, and swears like a sailor. He refuses to participate in most activities.

Leroy is labeled as having oppositional defiant disorder (ODD), attention deficit/hyperactivity disorder (ADHD), language learning disorder, and a few other titles thrown in for good measure. His denials of misbehavior are considered to be outright lies and proof of his ODD.

Children do lie to stay out of trouble. However, denials of misbehavior can also be indicative of dissociation. Events (and actions) that take place when a child is in a dissociated state often are not encoded in memory that is accessible to the other states of the child and, therefore, may not be available to the child later for retrieval. The child in one dissociated state might not remember what he is accused of doing, and did indeed do, when in another dissociated state. Similarly, the child might also have difficulty remembering consequences from one event to the next, appearing to not "learn a lesson" and to be disrespectful of boundaries (Lanius et al., 2013; ISSTD Child and Adolescent Committee, 2008; Silberg, 1998, 2013). Because teachers, doctors, and psychologists often do not recognize dissociative features in children, it is not unusual for dissociative children to have multiple misdiagnoses. This is particularly true when trauma is not reported. Professionals need to look beyond reported diagnoses to the child's behaviors and responses to understand what the child is experiencing, especially when the behaviors seem inconsistent or intermittent.

To control Leroy, Mrs. Tibo and Ms. Linda have reportedly "tried everything"—raised their voices, used a point system, punished, directed, confronted, and sometimes restrained. But discipline appears to roll right off of Leroy with no lesson learned.

Leroy has good days (rarely) and bad days (often). His bad days frequently follow an initial outburst, after which he continues to explode with or without reason. Most students give Leroy a wide berth. Others tend to provoke him. He is an ongoing challenge to have in the classroom, and his teachers are grateful to have him taken out of the classroom for services.

> Classroom teachers are often displeased when I "take their kids out" for speech therapy. The imperfect reality of treating children during school hours means they end up missing some of what their peers are studying when they already have many gaps. Ideally, the time the children spend in speech sessions should help them make up more than they would otherwise do in class and provide them with tools to do better future independent work. However, in a school atmosphere where state-wide test scores are measurements of a teacher's skills, it is not surprising that teachers resent anything they view as interference with their class plans. Some "tolerate" my intrusions into their class only because the children are mandated by law to see me. Mrs. Tibo and Ms. Linda, however, are more than happy to have Leroy out of the class for a while.

Leroy's out-of-control behavior is attributed (on record) to his short attention span and language-learning delay, and also (off record) to low motivation and overall no-good character. In fact, he is seen as "most likely to be dead or in jail by 18." In a supremely chaotic elementary school where police and paramedics are a familiar sight, this is not an easy status to attain.

Having witnessed Leroy's behavior first-hand, I was aghast to find out that he was not in counseling. Reportedly his family refused psychological evaluation, but I suspect that the school—already caving under the burden of too many children in need and too limited a staff—did not press the issue. Leroy was going to receive speech therapy ("Speech" hereafter), and this would have to do as the school's effort at intervention.

Leroy's reputation is well-earned. In the first weeks of our work together, he did not listen, refused to work, and repeatedly attempted beating up C.K., his speech-group partner. He pushed, touched, grabbed, provoked, and denied; his sheer physical strength made him hard to handle (and me black and blue). But Leroy shows more than just aggression. He can be quite paradoxically sweet and lovable, practically puppy-eyed in the moments he is not awash with fury. He is eager to please, easy to hurt,

and overly critical of himself. For all his rage, the boy is endearing, a heartbreaking elephant in the china-store of relating. I want to take him home and make it all better.

> These paradoxes in Leroy's behavior and demeanor are not like the relatively slow-cycling changes sometimes seen in children who might have bipolar disorder. Rather, Leroy can shift literally from one moment to the next and back, moving from fury to bewilderment to affection to desperate need. Such rapid shifts are often the hallmark of a child moving from one dissociative state to another (Silberg, 2013; Waters, 2005).

Now in the classroom, I walk toward Leroy. I keep my breathing even and hope to somehow transmit to him some of the compassion I am feeling for him. I visualize brushing off his agitation with gentle feather-strokes. I visualize his excess energy rippling softly and calmingly around and away from his body. I visualize him calming down.

> This "energy work" is not part of speech-language pathologists' traditional expertise, and I realize that it can seem a bit "out there" for some clinicians. And yet, I have found that using intentional compassion in visualizations can be extremely helpful as a calming method, if only for helping me to remain calmer during children's (and adults') distress. Children are, as a rule, acutely aware of the emotions of those around them. They rely on the adults in their lives and are therefore attuned—for good or bad—to the adults' state of mind. A distressed adult can be scary to a child because the child perceives that the adult may not be able to protect, comfort, or help the child; this adds to the child's distress. An angry adult can be terrifying, especially if the child had experience with angry adults who took their fury out on the child, or were otherwise out of control. A calm adult who can contain his or her own emotions has the best chance at calming a child because the child can sense that the adult would take care of the child and help the child regulate distress.

The boy turns to look at me, causing Mrs. Tibo to glance in my direction while still keeping one eye steadfast on Leroy's chair-missile. Exhaustion, frustration, and anger are written all over her face. I know she had repeatedly—and, I believe, appropriately—asked for a paraprofessional to assist her with Leroy, only to be told that "there's no money in the budget," and that, as she already had an assistant and a small class, she should make do. It did not matter that her class is small exactly because the children in it are already in need of an inordinate amount of personal

attention; or that a child like Leroy, who needs one-to-one assistance, commandeers more than his share of the teacher's time and energy. Mrs. Tibo was expected to "manage" her students, period.

"Hey Leroy," I say softly, stepping closer, "I came to take you for Speech." He stills, stiffens.

"Do you remember the project we started last week?" I continue speaking, keeping my voice calm, my sentences simple, my speech slow, and my eyes on the boy (and the chair). "We began making a paper-bag puppet. You chose to do the Lion King. You did an excellent job and colored it very nicely with markers. We were going to put some stickers on it today. Then we were going to glue a popsicle stick on it so you could hold the puppet and move it like in a puppet show."

Mrs. Tibo looks at me, part incredulous that I think Leroy (notorious for ongoing outbursts) would calm down enough to come with me, part disbelieving that he would even hear my soft voice in the staggering noise. Nevertheless, she seems relieved that he at least stopped thrashing the chair in her direction. I give her a quick nod of reassurance that I will be okay.

When children (and adults) are in distress, keeping communication direct and simplified can help them understand what we are saying and increases the likelihood that they can manage to respond to us. When a child is frightened or out of control, the areas of the child's brain in charge of processing language are suppressed by heightened activity in brain areas responsible for survival—for fight or flight (Lawson, 2013; Levine and Kline, 2007; Perry and Szalavitz, 2006). Distress is not the time for complex explanations or inquiry—those are best left for when the child is calmer and can actually process such information. It is also not the time to ask complex questions such as "Why did you do that?" or "What could you have done differently?" Simple narration to the child of what is going on now is most calming.

If it is necessary to get information from a child in distress, simple questions, such as "yes/no" inquiries to ensure safety or basic "who, where, and what," are preferential to more in-depth explorations. The most important goal is to help an agitated child get into a calmer state by, for example, reassuring that the child is safe, narrating to the child where he or she is and what you see, and being concise about what is expected of the child at the moment.

In this case, bringing up the Lion King puppet was also meant to remind Leroy of a time when he was calm and feeling safe, as a way to help him regain more calm in the present.

Leroy glares and does not move from his corner, but judging by the reduced zeal of his chair-jabbing, appears a tad less agitated. "We're going to be fine," I say, looking directly at him. "Right, Leroy? Nothing bad is going to happen. Everything's okay. You are safe. I won't hurt you, and you won't hurt me, right?"

He stares, nods. His shoulders relax a little, even as he maintains hold of the chair. Mrs. Tibo shrugs and turns to tend to the other children. Good. However unintended, her agitation only fueled Leroy's escalating aggression. He looks a lot more scared than scary to me.

"So," I continue, keeping my voice calm, "Everything's okay, Leroy. Are you ready to come finish your Lion King?"

By now, I am close enough to touch the chair. I reach slowly for one of its legs with my left hand so we are both holding the chair in what can easily become a tug-of-war. Leroy stiffens, but I do not move any closer or pull on the chair. We just stand together a moment, until his tension softens. There is no resistance when I gently take the chair from him and move it out of reach. Sliding my body a little lower to a crouch so I am not towering over him, I continue to talk about what we are going to do, keeping my tone casual but never taking my eyes off of him—he is as quick as lightening and I rather like my body unharmed. Leroy stares and blinks alternately. He looks dazed, as if unsure where he is.

Often, when children have been out of control (and/or been triggered and become dissociated), they go through a reorientation of sorts as they begin to calm down and in a sense resume awareness of the here and now (become "grounded"). They might look around, blink, take a deeper breath, shudder, and even seem puzzled about what just happened or where they are. As the child's body relaxes and the chemical cascade of stress hormones and other neurotransmitters is calmed and metabolized, the child may be able to "find his or her own way back" to a more settled place. Some children, however, may need more assistance to get grounded (Levine and Kline, 2007; Perry and Szalavitz, 2006).

For the most part, it is important to give a child time to become reoriented and not rush the child. This serves two purposes: it lets the child know that I can tolerate the space filled with his or her overwhelming feelings, and it helps the child learn he or she can come back to a more stable state and does not need others to control him or her. As children develop the ability to modulate their feelings, they often learn to reorient faster and do so more easily.

I offer Leroy my hand and he takes it. The boy's hand in mine, we walk toward the center of the room and a sea of spilled crayons for which he is probably responsible.

"Oh," I note in a neutral voice, "look at all these crayons on the floor. How about we pick them up before we go to Speech?" Leroy does not move to help me. He does not bolt. Good enough. He looks around, still reorienting. Mrs. Tibo looks at me disapprovingly as I bend down to collect some scattered items. She has told me before that "my coddling" when a child misbehaves is not her idea of "helping them learn there are consequences for misbehaving."

Children do need to face the consequences of their actions. However, when a child is raging, they cannot process information anyway—the child's brain is busy with survival aggression. Leroy will need to learn to modulate his rage, yes, but at the moment the goal is to help him learn that he (and others) can survive his rage, rather than to test his ability to accept it. Additionally, and given Leroy's tendency for amnesia for things he does while in a rage, he might not remember it was he who made the mess. He would need to be talked to about it, but not right now.

In the end, Mrs. Tibo has little cause for dissatisfaction because Leroy helps pick up the remaining crayons without being told to.

"Thank you, Leroy," I say once we are done, "this didn't take very long, did it? Do you want to say 'Bye' to Mrs. Tibo?"

He looks at her then back at me and mutters: "Bye Mrs. Tibo." His voice sounds confused.

I kneel beside him in the empty hallway and he leans into me. I drape one arm gently around his shoulders. "I'm sorry that you're having a rough morning, Leroy. I'm happy you decided to come to Speech with me."

Quite bewildered, he remains leaning against me for a moment.

"What's your name?," he asks shyly for the umpteenth time.

Using touch with children is something I do with awareness and care. It is not touch itself that is the problem: speech pathologists touch children as part of clinical practice all the time. We check mouths and tongues and cheeks and lips, look at teeth and mouth movements and palates. We stabilize jaws and straighten shoulders, and feel for abdominal breathing. We work hand-over-hand and let children feel our own breath or vocalizations. We use our hands and tactile information to signal many things that nonverbal children might not understand or might need help with. It is natural for me to touch children for communication, as well as to offer comfort.

However, it is crucial to assess a child's comfort or discomfort level with physical proximity and touch. I often wait to have the child initiate contact with me (unless it is an emergency where I need to keep a child safe from

himself or others). Most children let me know about their body boundaries by how much distance they keep from me and how they touch me (e.g., my arm, my bracelet, my hair). Children communicate their comfort with proximity by how closely they move toward a person, or lean to better see something another person holds. They communicate the dilemmas in their bodies when they sometimes simultaneously lean into and away from me. It has been my experience that most children allow touch once they feel they have the right to refuse it, stop it, and move away from it. That said, when dealing with children who might have been maltreated, it is important to remain aware that not all of them find touch comforting. Some children can find any touch triggering and retraumatizing. Touch can feel scary and intrusive. I am doubly careful with children who have (or are suspected to have had) trauma history, be it medical trauma or interpersonal trauma, as well as with children who have sensory hypersensitivity (e.g., autism). For these children, even casual touch can easily be overwhelming. Caution does not mean avoidance. In fact, when used with respect and awareness, touch can often be comforting and soothing; and it can help ground a child who is otherwise "lost." Not all professionals are comfortable with using touch and, generally speaking, if one is not comfortable with touching a child or being touched by one in a clinical setting, then they probably should not include touch in exchanges. Ambivalence about physical contact is always communicated; and all children—especially maltreated children—are acutely tuned in to such ambivalences.

Leroy was all too familiar with being touched—he was very often restrained, held by the hand, tugged back—and would respond by fighting back and getting angry. He used touch in a similar way—to push, grab, choke, and tug. Giving Leroy an experience of gentle touch appeared as important as enlarging his vocabulary. The first time he saw a classmate lean into me, Leroy knitted his brows together in concentration, stared for a moment, then presented himself at my other side and leaned as well. It seemed he was testing to see how I would respond. From that day on, he would often lean into me, side to side, cuddling into a one-armed hug.

I remind Leroy of my name. It is something I have had to do many times before. He nods shyly in half-recognition and walks with me. Part-way down the stairs leading to the first floor's auditorium, where my office is in a stage's old dressing room, Leroy shudders. The growth in presence is almost palpable, as his awareness appears to fill his body and reoccupy his mind. It is a startling transformation. Confusion gone, Leroy becomes a ball of kinetic energy. Letting go of my hand, he bounces ahead. He is animated and bubbly. "Come on Miss Y!" he yells, and swings the door open so it hits the table with a bang. By the time I take a step into the

small room, he is already at the table, swinging the half-finished Lion King puppet I had set out.

"It mine?!" he inquires, no real question in his voice.

"Yes it is!" I reassure. "See up here? You wrote your name on it last time."

He smiles.

Delving into the activity, Leroy decorates his puppet while we review the adjectives we learned last time as part of the description of his choices for colors and glued-on accessories. Verbalizing is hard for Leroy, but his challenges go deeper than art-project vocabulary. Leroy has difficulty describing things he did as early as the day before, cannot list what he had for breakfast, and sometimes cannot remember the names of his classmates or his teacher. He keeps asking for mine.

> I have worked with children who had word-retrieval issues—akin to perpetually having words evasively at the tip of the tongue—but Leroy's behavior is not characteristic of this problem. His loss for words is mostly for personal things and is transient—one day there, one day not. This might be an indicator of dissociation, where in one state he has access to this information, but in another state he does not. He does not understand sequence, how one thing leads to the next; he cannot predict the ending of a story or the consequences of actions (either his or others'). Series of pictures are to him separate, fragmented happenings even when depicting everyday events such as someone getting dressed, a boy pouring a glass of milk, or the steps of making a puppet. He is completely lost when it comes to taking turns, and he is blind to social cues. He does not know how to play and uses toys as pounding objects, not imaginary props. Joyanna Silberg, in her book *The Dissociative Child* (1998), noted that such stereotypic play behavior is common in maltreated children. Leroy's specific history is not clear, but his presentation certainly raises questions.

Once his puppet is finished and set to dry on the windowsill above the hissing radiator, I take out a couple of toys and simulate a "Simon Says" game. Leroy struggles. He cannot hold in his working memory even simple directions such as "turn around," "close your eyes," or "touch the table." He needs numerous repetitions. Nonetheless, he delights in the activity and laughs at the sillier directions I intersperse.

With little warning, his attention sputters. He has difficulty coming up with things for me to do, and cannot even echo some of the things I asked him to do a moment prior.

What Leroy's teachers view as "unwillingness" to work seems more like fluctuations in ability. His denial and shifting abilities (frustrating though they are) do not feel like manipulations to get away from doing work—Leroy behaves this way even with activities he tremendously enjoys. It looks as if he truly forgets skills he could do before. This is indicative of more complex issues or dissociation.

Children's behavior often changes with circumstances. In Leroy, these changes are more extreme than one expects. More importantly, he seems unable at times to retrieve skills he had moments prior. The extreme and abrupt shifts in mood, abilities, and behavior are so common in Leroy and so visible, that the teachers often state "oh, there he goes" when they see him getting upset or "losing interest." Such shifting raises red flags to possible dissociation. Even though, at this time, it is not clear what could be at the base of these behaviors, it is important to keep note (Silberg, 1998, 2013; Waters, 2005).

I do not try to process the shifts in behavior with Leroy. I do not ask what they mean, what he remembers of them, and so forth. This would be the work of a therapist, if he had one (not to mention that his poor language skills would present an obstacle for verbal processing at this point). I respond to Leroy as a whole child by commenting and accepting all his behaviors as part of him. I fill in the gaps when he seems lost but still require him to be accountable for whatever happened, aware or not.

Regardless of the reasons for his difficulties, I cannot blame Leroy's teachers for being exasperated—he is very difficult to manage, and his ever-shifting demeanor threatens to leave his caregivers with permanent hanging-jaw disease, not to mention badly bruised shins. He is alternately as wide-eyed as a toddler, or as ruthless and profane as a wrestling pro. And yet, what some call "attitude" can just as easily be called "something broken, but where?" Children spend most of their waking hours in school. For eight hours a day, they are in a potentially safe and reparative environment. With millions of children suffering from the impact of trauma, one would expect the educational system to be geared to identify and support them, but this is not so—or, at least, not yet (Yehuda, 2004). Many teachers can cite the symptoms of ADHD, but few, if any, can do the same with posttraumatic presentations. A child's inability to remember, fluctuations in ability, staring into space, and unprovoked aggression—even when abuse history is known—are often labeled as attention deficit or conduct disorder, rather than possible posttraumatic or dissociative symptoms (Cohen, 2001; Cole et al., 2005; Putnam, 1993, 1997; Waters, 2005).

Leroy does not sense he misses information—he denies he was already told anything, and tends to lash out at the suggestion he forgot. He refuses to continue, cries. He will not attempt things he completed easily just moments prior. "I can't do it," he pleads. "I don't know how."

There is no social history in Leroy's file. He is exceptionally well-groomed and appears well-fed; his clothes are clean and his shirt pressed; and he attends school regularly.

This is my eighth session with Leroy, and he is still a study in contradictions. I make a note to ask the special education supervisor about him and to chat up the paraprofessionals who rotate among classrooms. He has been in this school for three years. Someone must know more about Leroy.

When I go to pick up Leroy the next time, C.K., Leroy's speech-therapy partner, is back in class after a week's absence. C.K. is always in motion and tends to be impulsive. Leroy might have used the calming influence of a less active child, but in a strange way the two socially awkward boys get along relatively reasonably. On some level, they may understand each other. Interestingly, C.K. is receiving counseling, but Leroy is not. The psychologist could not explain why other than hint that C.K. is seen as having "more potential" than Leroy.

Leroy bounds to the door like an arrow released from a bow. I quickly write the children's names in the class's sign-out book, and the three of us leave. I hold out my hands and the boys take them, skipping and twirling at my sides. I remind them of our routines: it is C.K.'s turn to unlock my door, and Leroy would get to lock it when we leave. The little routines were installed after experiencing first-hand the need for minutely spelled-out structure with these two.

Once in my office, the boys launch into their assigned seats, and C.K. immediately asks to see the SpongeBob coloring books I had promised him the last session. He smiles when I place them on the table.

"You not lied," he asserts.

"No, C.K.," I reply, "I didn't lie. I don't like being lied to—it makes me sad and angry—so I try not to lie. I wouldn't lie to you."

Leroy bangs two toys together, but only half-heartedly. He is uncharacteristically quiet as his eyes move from the coloring book to me and back again. He appears to want to ask something but is holding back—for all his impulsivity and aggressiveness, he can get awfully reticent at times, presenting a heartbreaking insecurity.

Leafing through the coloring book, C.K. comes across a page filled with stickers of the cartoon characters. "Who that for?" he tries.

"For all the kids I work with." I smile. "When we're done today, you can pick a sticker for yourself."

Leroy sits up straighter and keeps banging the toys together. He says nothing. I let him observe.

Group sessions can often be utilized for modeling language interaction with one child while the other observes and lets it in. Sometimes a little distance gives the children who are less able to communicate a safe place from which to experience the interaction without having to be active in it yet. They can often be seen mouthing words others are saying, mimicking facial expressions, and "practicing" silently until they have gathered enough learning (and courage) to try to risk communication (and possible communication failure). It appears to be what Leroy is doing now.

He looks interested in the exchange and is hanging on every word either of us says. For a child who has such a difficult time with listening, this is already a goal achieved. Children are often the most motivated when they are invested in what is going on. The topic of lies and truth is an enigma to Leroy. In addition, as with many of the children I see in the schools, I suspect that his experience with kept promises is scarce.

"Every time I come I get one?" C.K. presses.

I chuckle. "Well, the stickers won't last forever, C.K., but there'd probably be some left when I see you again this week and maybe even for next week."

"What if I bad?" C.K. challenges, eyebrows knitted in concentration. He is going for tricky territory here.

Leroy stops pounding the plastic farm animals on the table, listens.

The issue of prizes and the numerable ways with which a child will miss on getting them is an ever-present issue. There has not been one child this year (or many in years prior) who did not ask it in some form. Be it the cookies in my tin box, the pretzels I keep handy, or the small stickers I often dole out—nothing is perceived to be allowed just because the child is worthy, or because sharing a treat is pleasurable. Everything in these children's school experience (and life?) is bound into an adult-controlled "good versus bad," reward versus punishment, and gifts versus deprivation.

It is clear that inappropriate behavior should not be rewarded, but these kids have so much of their lives policed that they are hungry for unconditional acceptance and understanding (and sometimes food). Whenever possible, positive reinforcement is preferred to repercussions. It is important to not condition all of a child's delight in simple things on the child's behavior.

A child might lose the time to play a game if they wasted session time even after being warned, but that does not change whether they would get to keep their work or a midday snack. Mine is such a foreign approach, however, that the children ask and ask and ask.

"You will get to choose a sticker because I'm happy to share them with you guys. It would, though, be much more fun to work together if everyone tries really hard to keep the rules and we do not waste time, right? Remember what the Speech room rules are?"

The boys quip in unison: "Stay in your chair. One person talks at a time." Soon both boys are busy working, and the session progresses without much disruption or upset.

A deafening sound jars me, sending Leroy flying out of his chair and the crayons, like projectiles, to the floor.

I place a soothing hand on Leroy's shoulder—he would not be able to hear me over the noise even if I shouted. The boy is shaking.

"I'm sorry, Leroy," I say as soon as the din stops, "this bell is awful. It startled me, too. It's Ms. Y, Leroy. Everything's okay. It was just the loud bell. I'm sorry it scared you. Let's get the crayons back into the boxes, okay?"

Leroy's eyes stare back wide and glazed. He trembles. His eyes slowly come back into focus. After a deep shuddering breath, he smiles shyly, uncertain, confused.

I repeat what had happened—the bell, the sudden noise, me startle, the scare, him safe. He is in my office, the noise over, him safe.

> I often repeat a narration of something that happened in the room—especially if a child was startled. It is important to ascertain that the child is able to understand what I was saying, and not to leave them confused. I do not know if Leroy comprehended anything I said the first time around. It would not surprise me if his reorienting and calming had been more to my tone of voice and comfort, than to the words themselves. Still, it is important to put the event in context; hence, the repetition when the child is less activated (ISSTD Child and Adolescent Committee, 2009).

Leroy nods. He is still shaken, but his eyes are not blank anymore, and his breathing slows. Together, we make short work of cleaning up, and by the time we need to leave, Leroy is calm.

Christmas is closing in, and by the end of the week the school has transformed into a study in tinsel and candy canes. Leroy's excitability skyrockets. Already struggling to self-regulate his emotions, he alternates between bouncing off the walls with agitation, running in the hallways with shrilling laughter, or staring off into space in a daze.

> Holiday seasons are complicated for most people, and even more so for many of my students—those not with their families, those whose home life brings more misery than happiness, those who have no home. The veil

between reality and fantasy is thin this time of year, and the children visibly struggle to fit the storybook holiday they are indoctrinated to believe in with what they actually live and can expect.

As a clinician, it is crucial that I differentiate my own "stuff" from that of the children and that I shift away from my own anxiety—and my anxiety for them—in order to be more aware of their experiences. I am aware that some of my anxiety for them is activated by my own recollections. Poverty is not new to me. For much of my childhood, my mom dressed me and my six sisters by sewing what she could, handing down from older to younger child, and buying secondhand. During especially difficult years when my father was in jail and my mother on welfare, kind neighbors left cartons of surplus seasonal fruit or eggs on our doorstep under the cover of darkness. I understand the sting of having less.

My childhood took place across an ocean and a sea from New York's inner-city, and my house was not as wretchedly poor as some of my students'. I do, however, know the feel of soul hunger, the need to pretend a reality that is not so much so that one believes it.

My students are managing discrepancies bigger than those I grew up with: they are bombarded with supposedly ideal (yet mostly unattainable) images of presents piled under trees as families in matching new pajamas gather around a roaring fireplace. It is to them a fairy tale they somehow need to attain. As with Leroy, they stand upon a narrow bridge of hope between excitement and despair. And every year, some fall.

It is important that I contain my own anxiety and dread for my students' disappointment, so it does not contaminate their own experiences. Relationship dynamics are crucial to children, and I can help them by providing support and openness to their experiences without my own baggage.

I pick up Leroy and C.K. from the classroom. As we walk down the hallway, Leroy stops by a Santa Claus cutout. "Santa Claus," he comments, touching the cutout and adding boastfully, "he come to my house every day." C.K. cackles and I tighten my hand slightly around Leroy's, anticipating war. But Leroy seems not to have heard C.K., or not to care. He stops to touch every Santa Claus we pass and repeats his comment verbatim, as if on automatic. A line of kindergartners snakes alongside the wall across from the bathrooms, but Leroy moves through them as if they are not there, trying to get to a Santa Claus figure. He shoves one of the children in the process. "Hey!" the little boy protests, "I standing here!" but Leroy looks right through him. He seems completely entranced.

"Leroy," I state, gently, "I know you wanted to touch the Santa Claus picture, but you need to be gentler. You just pushed this little boy aside. Can you please tell him you are sorry?"

Leroy stares at me, baffled. His face darkens and he looks about to explode in rage.

"Leroy," I say, "This is Miss Y and I need you to look at me. I don't think you meant to push him but it happened. And when we push someone even by mistake we need to say we're sorry. Right?"

He nods absentmindedly and starts to move away.

"Leroy . . . can you apologize to the boy for pushing him by mistake?"

He looks up at me, at the boy, back at me. "I sorry," he mutters, still confused.

"Is okay," the kindergartner chimes, quite pleased to be granting pardon.

As we move on, Leroy looks behind him at the line of children.

"I'm glad you said you were sorry, Leroy," I commend. "It was the right thing to do. I'm proud of you for listening, too."

Leroy smiles shyly. A moment later he shudders, his face brightens, and he is practically bouncing off my hand. We pass two more Santa Clauses on the way to the auditorium, but Leroy does not even grant them a look.

"Hey, Leroy, here's another Santa," C.K. announces.

"Santa's stupid," Leroy comments derisively. "I not a baby, man."

C.K. shrugs.

Leroy's shifting behavior is at best confusing. His preoccupation with the Santa Claus figures had a compulsive, almost perseverative quality, which made his final remark even stranger. It is possible that he was angry at my interruption of his "game" and had now lost interest, but my sense is that the shift was deeper, that he had been in some "bubble" of experience until my request that he engage with the boy he had pushed forced him to shift his focus. This resulted in him "snapping out" of his repetitive occupation with the Santa figures. Framing the exchange in a non-blaming way probably also helped Leroy avoid exploding in indignation, allowing him to engage again without being triggered into rage.

The teachers often ignored supposedly "minor" instances (i.e., no one was visibly hurt), not wanting to risk Leroy's wrath. This might be how his environment adapted to him but is not helpful in the long run, as it reinforces Leroy's lack of awareness of what takes place. He needs to be made aware of what he does—without being shamed or blamed—and to learn that he is responsible for the results of all of his behaviors. By becoming accountable, he can learn to maintain more awareness, or at least be more open to the idea that there is a part of him that reacts without his being aware of it. By stating the fact that bumping into someone happens and requires an apology, I was letting Leroy know he was not singled out and is expected to be attentive to how others feel, just as others would be.

It was important to praise Leroy for his willingness to apologize. His apology showed a beginning ability to modulate his rising anger and relate

appropriately. What might seem like simple social moves at his age are new interactions for Leroy, who spends so much of his time spaced out and reactive that he is socially inept. By becoming a positive encounter, this incident may have helped strengthen a new skill for Leroy. His derisive comment about Santa at the end, while seemingly angry, actually felt more "there" than his previous automaton-like comments.

Finally in my office, I ask the children about their holiday plans. C.K. chatters with abandon, eyes sparkling with expectancy and possibility.

Leroy seems lost again and there is an urgency in his voice and eyes—a look that stares beyond me. He seems as if he is trying to copy stories I have heard from other children, only he cannot quite keep the theme together.

Children who dissociate can have difficulties focusing even when they are not directly dissociated. When a child spends much time detached from exchanges around him or her, the child misses on opportunities to learn how to follow a theme, tell a narrative, and keep on target. If their experiences are fragmented, they will have little experience with remaining focused, and appear scattered even when they are present. It is important to help the child not only increase the ability to remain present, but also to teach what being focused is and the skills with which to maintain it (Osofsky, 2004; Pearce and Pezzot-Pearce, 1997; Yehuda, 2005).

"The white man from the mall he . . ." he starts, "He white. He red. He bring me a Xbox from the mall. He red. All red . . ." his voice trails off.

"Santa Claus he going come down the chimney," C.K. states, "He not come from the mall no more when it Christmas. He come from the North Pole."

Leroy's eyes darken. "Yes he be! He be in the mall!"

This seems to be one of those times when Leroy's limited language comprehension and difficulty with sequence and time stands in his way of effective communication. Not understanding that C.K. is referring to a future time, it seems Leroy believes that C.K. is negating that he had seen Santa Claus at the mall; and he is angered by being seen as lying.

While Leroy seems relatively present in this interaction, his communication challenges are clearly not limited only to when he is dissociated. Children who dissociate often suffer the consequences of the time they spent "away" while other children learned new things, interacted with peers and adults,

and practiced their social and language skills. This is part of the high price dissociation exacts of children and part of what must be actively addressed in a child's intervention (Cole et al., 2005; Silberg, 1998, 2013; Waters, 2005; Yehuda, 2005).

I calm the boys down by redirecting them to an activity where we work through the steps of card writing and gift wrapping, and discuss things that can or cannot fit into boxes of certain sizes. The boys shriek with glee at my repeated "mistakes" (such as thinking that a horse can fit in a shoebox, or a car in a suitcase).

Later, I gently return to holiday plans. Leroy says nothing, and it occurs to me that I still know very little of his home life. He lives with his grandma but that means little in this school where family configurations are often multigenerational. Where will he be? Who will he spend the holiday with? What is it like in his house?

When C.K. presses and asks him about the upcoming vacation, Leroy gets confused and upset. He throws stuff on the floor, maybe using behavior instead of words, or shifting to an angry place that has no words. I wonder if he cannot say more, if it is too hard.

If I had been more in tune with Leroy's mood, I would have seen that he was reacting to holiday-related things—his preoccupation with Santa figures, his muttering about the "white man in the mall." He was showing me that he was anxious, but I did not pick up on it at the time, wanting the children to have the language tools to understand and respond to everyday questions about the holiday. For all the necessity of learning to speak about real-life events, which is important for social language, my asking personal questions about the holiday was too much. It would have helped if I had information about what the holidays might be like for Leroy. School staff often know little about children's home life. It is important to be super-careful not to make assumptions when it comes to what a child can manage, or we may end up forcing the child to use the very coping skills that keep him or her from being able to interact more fully. When it comes to children who manage overwhelming distress, the smallest clues—his monotone muttering, the spacey behavior, the shift in behavior regarding the Santas—need to be attended to, and no topic can be assumed neutral.

"My dad he buy me anything I want," I overhear one of my students state as I escort the boys to the lunchroom to meet their class. "He going to come take me to Disneyland and he be buying me anything I want!"

Holding my hand, Leroy stiffens. I tug on his arm gently in reassurance and to help ground him. He looks up at me, eyes wide and so very young.

I am not sure why he shifted from stiff to vulnerable, but I wonder if it was the comforting reassurance I had offered. I want to take him in my arms and comfort him. Instead, I smile at him, make eye contact, and focus on helping him get grounded and letting him know he is seen. Leroy shudders, calms.

The clash of hopes and imminent reality makes for a highly combustible atmosphere. Teachers, too, are not spared the holiday stress and react in harsher ways to little things, inadvertently adding to the children's stress.

Leroy's outbursts in class escalate to new heights. Maybe the heightened stress levels lower his threshold to events that at other times may not trigger him.

In the last session before the holiday, and while working on a coloring pattern, Leroy keeps muttering in a chant-like rhythm: "Shut your mouth, shut your mouth, shut your mouth."

When C.K. tells him to be quiet, Leroy explodes, kicks the table, and yells, "I didn't say nofin! I didn't *say* nofin!"

I change the subject (to avoid WWIII) and suggest a sing-along of a song they both like. He obliges, but after a line or two starts substituting the familiar lyrics with "shut your mouth, shut your mouth, shut your mouth," still carrying the melody. My training as a speech-language pathologist would cue me to view the intrusion of this sentence as possible perseveration—a difficulty changing "gears" from one response to the next—but is it? Why now? Why these words?

After a moment or two of this, C.K. loses patience and tells him to "shut up already!"

Leroy goes rigid, crayon poised over page, and emits a stream of words: "Shut your mouth or I'm gonna' beat your sorry ass into a pulp! Shut your mouth or you gonna' be sorry you alive." This out, he goes on coloring as if nothing happened, back to his rhythmical, "shut your mouth, shut your mouth . . ." C.K. rolls his eyes.

Beyond the obvious semantics, what disturbs me most is the discrepancy between Leroy's lack of emotion and the violent content of his words. The boy actually seems relaxed now, rocking as he mutters and colors, free of any malice or even awareness of his words. He looks in trance, in his own space.

Later on in the session, while involved in other activities, Leroy participates happily, his mumbling gone as quickly as it came.

The out-of-context intrusive phrasing, along with Leroy's seemingly relaxed demeanor and lack of awareness to what he was saying (or why) are a strong indicator of dissociation. What he was saying had no connection to the session, and it appears that when he got upset with C.K., he was not aware of his own words, or in control of the stream of words he emitted later on. His response to C.K. appeared to be more of a triggered, almost automatic

response to C.K.'s demand that he "shut up" than an actual enraged response, especially as Leroy did not follow his words with the usual aggression—instead, seeming completely numb and spaced out. Rocking is often indicative of self-soothing, and the disappearance of the mumbling without any comment or acknowledgement that anything just took place is significant, too, as it might represent yet another dissociative shift. It is possible that the introduction of other activities served to help ground Leroy so that he returned to a calmer state.

On the way back to class, Leroy, now in a good mood and seeming completely oblivious to the events of the session, inquires if I would tell his teacher he "was good." It is a frequent, almost routine, request.

"No you not, you be bad!" C.K. chirps maliciously, "you said bad words and the teacher gonna' call your home."

"I didn't!!" Leroy cannonballs onto C.K. "I was good! I didn't say nofing!"

When I speak with his teachers later, I find that similar muttering happened in class and was challenged as inappropriate language. Insisting on enforcing a rule regardless of a child's situation or comprehension may not be optimal, but the teacher's dilemma is understandable—not to apply the same rule to all children can seem to be singling out for preferential treatment or condoning the behavior. A better approach would be to confront the child without blame and enforce consequences (e.g., time out, an apology).

It takes all my strength to peel the two boys apart until finally I am sitting on the floor with my arms securely around Leroy's torso, him facing away from me. C.K. keeps a safe distance against the opposite wall. Leroy writhes in my protective bear hug. Sobbing dejectedly, he feels much younger than 7 to me.

"He say the teacher gonna' call my home!" he weeps, "I didn't do nofing! Why you gonna' tell her call my home? I was good, I didn't say nofing! I didn't do nofin . . ." He sounds devastated and seems not to remember what he said earlier.

"It is okay, Leroy. You are a good boy to me," I reassure, turning him gently so that he faces me. I decide not to comment on whether or not he said "bad words" but, for now, to relate to his general behavior in session. "You worked hard to stay in your chair and you did your work. That was good behavior."

He sobs on, devastated, and I do not think he heard me. I repeat what I said, reassuring him again that everything is okay. Finally, his dark eyes

open onto mine, wide and wet, relieved. "I was good? You gonna' tell my teacher I was good?"

"I certainly can say that," I reply. "Didn't you work hard to stay in your chair today?"

In retrospect, I wish I had made a nonjudgmental comment about all of his behavior in session—muttering included—rather than only focus on what he did well. Helping a child become aware of his varying behaviors is an important part of reducing levels of dissociation. Such a description would still have included his working hard to stay in his chair, and that would be reported to the teacher.

Practically levitating, Leroy bounces up from my lap. "You see," he announces to C.K., vindicated, "I was good! She gonna' tell the teacher I was good!"

C.K. eyes me suspiciously and states—not to be short-changed—"I stayed in my chair, too."

"Yes you did!" I reply, "You both worked well today." Back on my feet I keep hold of their hands as an anti-escalation tactic. "Sometimes you have a hard time listening or use words that aren't appropriate. Sometimes you have a rough day or forget how to listen. But you are good kids to me. Today, Leroy, you stayed in your chair, and C.K., you tried to be patient. You both did well! I like working with you!"

That last statement gets them frowning. Unaccustomed to praise or being liked, the boys look at me as if I had fallen from Mars.

Though seemingly out of context, I do make it a point to tell children I like them for themselves and to find something to praise them for while limiting listing what they did wrong. Many have had precious little experience with anything but constant direction and correction. Good behavior often goes unnoticed while bad behavior receives attention (scolding, warnings, and consequences). Many of my students pass through multiple foster homes and overwhelmed households, and have more experience with dismissal and betrayal than with care and kindness. It comes as no surprise that they often disbelieve their own worth or lovability.

Employing the "you are a good kid tactic" is not just to help children feel better. I truly do believe they are good. In addition, children cannot internalize something for which they have no experience (Baron, 1992; Bowlby, 1997; Denham, 1998; Kagan, 2004; Osofsky, 2004; Schiefelbusch, 1986). How are they to recognize pride, happiness, affection, or gratitude if they have not felt them? They can hardly be expected to have goals beyond avoidance

of punishment without an opportunity to feel there is more. Praise, though initially taken with a pound of salt, happily takes root once children see I really mean it.

Two days before the holiday vacation starts, my excavations into Leroy's history are finally fruitful (even if sketchy). He lives with his paternal grandmother, who has custody of him, custody which his mother contests. Visitations with the mother (according to a teacher who lives close-by) are spent with the mom bad-mouthing the grandmother. The grandmother, in turn, bad-mouths the mother and often within earshot of the child, and both use the boy as a conversation pawn. His father is in jail, serving a long sentence for crimes unknown. Why the mother lost custody is unknown, too.

Leroy reportedly spends afternoons until dark outside—rain or shine—with minimal supervision. His teachers confirm that repeated requests to the grandmother to assist him, or at least supervise his homework, go unheard. Grandmother claims that Leroy is a bad kid and that she has her hands full keeping his ass straight (read: "whooping him") without doing the teachers' work for them.

Maybe it is not a mystery where Leroy learned to say "Shut your mouth or I'll beat you into a pulp." But is there more to this than an undesirable (but maybe not illegal) manner of speech? Is he at a real risk? Does she make good on her threats? Do I need to make a report?

Working in the Bronx and Harlem, I (sadly) learned that a certain degree of familial corporal punishment is considered culturally acceptable, even commendable, as means of "teaching children respect" (even if, in reality, it appears to teach children fear, cunning, and that physical advantage confers power). The line between spanking and abuse can be blurry. Leroy shows no signs of bruising. He also tends to call the slightest touch "being hit"—is he oversensitive, overdramatizing, or triggered by nonviolent touch to remember touch that was violent? Either way, why?

It seems to me even more now that Leroy's psychological needs ought to be evaluated and addressed. Any evaluation, if to be paid by the Board of Education, needs approval of school staff before parents or guardians can be contacted. I head down to the School-Based Support Team office.

The school's psychologist stares at me a little cross-eyed when I describe Leroy's behavior and mention "history" and "possible trauma reactions." He tartly suggests that it would be better if I stuck to teaching language rather than meddling in areas I have little understanding of. This is a reaction I am familiar with from those who consider my psychological

inquiries as encroaching on "their turf." I bite my tongue, reminding myself that I am not above prideful reactions, swallow my indignation, and breathe deeply.

> The vacuum in the educational system regarding understanding and recognizing (let alone treating) the traumatic aftermath in children is not limited to this psychologist. Most school psychologists (and speech-language pathologists and other education staff) are not trained to recognize or attend to trauma reactions in children. My goal is to help change that, and thankfully I am not alone. The problem is increasingly recognized by leaders in the child-trauma field, who encourage education and collaboration between professions to better children's lives (Cohen, 2001; Cole et al., 2005; Silberg, 1998, 2013; Waters, 2005).

"I am trained to notice signs that a child needs further evaluation," I press, "and am concerned about him. He is aggressive, has considerable difficulty regulating his emotions, and is often confused about events that just happened. Clearly that's not considered normal for a 7-year-old."

The psychologist rolls his eyes. "He's a bad egg, this one," he states. No, he does not think Leroy needs counseling. "He has ODD. Do you know what that means?" He peers over the rim of his spectacles, and continues pedagogically: "Oppositional defiant disorder—children who don't want to follow rules and manipulate everyone to do what they want without caring about consequences. He can be a poster child for the diagnosis."

"Then why isn't he in counseling?" I push. "Did anyone check why he might be presenting this way?"

The psychologist rolls his eyes again. "Everyone in this school has had trauma, what do you expect—that they all be in counseling? [Yes . . .] He should be grateful that at least he is with family."

> Exasperation aside, there is truth to the psychologist's claim regarding the prevalence of trauma and the boy's relative good fortune at not being carted about the foster-care system. As far as the system is concerned, Leroy is expected to count his blessings and change his behavior in the now, without an interest in why he got to be this way or what might help enable him to change. His behavior is seen as a case of bad personality, not a reaction to his world and the trauma he has likely experienced.

Peering at me through his glasses, the psychologist then lowers his eyes to the desk and scribbles a note in another child's file, making me wait.

"Well, Ms. Yahuga," he crunches, mispronouncing my name, "I will do my best to look into it. I suggest you focus on doing your job. He has a learning disability and is clearly oppositional defiant. He is already in special education. Not a lot up in the attic, if you know what I mean," he taps his temple, chuckling. "Have you considered that may be why he doesn't participate in things? That'll be all," he adds with a dismissing swing of his hand and goes back to his notes.

I make a point not to slam the door as I leave. Then I take deep breaths, counting to ten and then some. Not usually quick to anger, somehow the psychologist presses all my buttons. Stalking back to my office, I comfort myself that, with his attitude toward Leroy, the little boy is probably better off not seeing the psychologist anyway.

I am discouraged but decide to find out more about Leroy and his possible dissociative behavior. Conferencing with parents and teachers is within my scope of practice. Also, if dissociation affects language and communication, it is certainly important that I know all I can about it. I can work to help Leroy remain more grounded, and more able to process and express information.

Improving communication in children who are experiencing emotional overwhelm, or who are protecting against such overwhelm by dissociating, is important. Being able to verbalize an event can prevent it from becoming dissociated from awareness (Herman, 1997; Pearce and Pezzot-Pearce, 1997). The ability to communicate internally is crucial for a child who shifts between internal parts. Having better communication skills can help a child express his or her needs, fear, and anger, and thereby spend less time in a hyperaroused, terrified, raging, and confused state. Verbal and nonverbal communication also enables the child to stay connected to another person, and thus be more grounded and easier to be soothed (Baron, 1992; Bowlby, 1997; de Boysson-Bardies, 1999; Osofsky, 2004, 2011). Language puts experiences in context, and having access to that context can diminish the negative impact of an event. Having communication does not resolve the causes of dissociation, *per se*; however, improving communication skills is essential, as an uncomprehending state essentially robs the child of the ability to process new information, so the child cannot take advantage of learning opportunities (Levine and Kline, 2007; Putnam, 1997; Silberg, 2013).

If a child cannot verbalize self-states or emotions, or has limited understanding of sequence and consequence, the child will struggle to describe his or her reality and experiences; the child might not understand why he or she is being punished and might not know how to reach out.

There is yet no training protocol (in my field, or the mental-health field) for teaching language and communication to children who show trauma and

dissociative symptoms. In general, it is helpful to go back to basics, not to assume the child understands what is often taken for granted regarding interaction and communication. Children learn through early interactions with caregivers. They associate the sensations they get from their bodies with their caregivers' narration and actions (e.g., "What's wrong? Let's see why you are crying . . . oh, your diaper is wet . . . that doesn't feel good, no wonder you're upset . . . let's get you more comfortable . . . there . . . all nice and dry . . . doesn't that feel better?"). Babies learn to recognize body states quite early through feedback of their caregivers. By the time toddlers put words together, they can often name basic body-states and emotions such as hungry, mad, sad, and happy (Baron, 1992; Bowlby, 1997; Denham, 1998; Schiefelbusch, 1986).

Understanding information coming from one's own body and recognizing everyday routines help a child make sense of his or her world and experiences. However, children who are not taught these connections—due to caregivers who are absent, absentminded, neglectful, confusing, scary, or hurtful—may not learn to recognize self-states, or may label them incorrectly (Heineman, 1998; Osofsky, 2004, 2011; Putnam, 1997; Silberg, 1998, 2013).

It is important to teach these basic schema and associations to children such as Leroy—to model sequence in daily routines, actually to go through the steps, to teach cause and effect of everyday happenings—What will happen if too many blocks are piled up? Why did the tower collapse? It is important to offer scaffolding for narrative by verbalizing everyday context and events, and to model description, prediction, humor, and play. In essence, help the child establish a communicative repertoire.

Working with Leroy in the following weeks, I teach him about internal states such as "hungry," "tired," "thirsty," "sick," as well as everyday emotions. As winter unfolds, I play-act and model episodes of gurgling tummies and dry throats in dolls wanting my cookies and needing water; who then feel full and satisfied. When Leroy tosses dolls on the floor and roars in laughter, or just leaves them there without another glance, I model how the dolls get comforted, kissed, and bandaged. He stares wide-eyed at these exchanges, sometimes "helping" a toy fall just to see how I would react, and smiling in some satisfaction when I predictably ooh and aah over the toy's perceived hurt. The dolls lie sick in bed and get medicine, get wet and cold and need toweling and a change of clothing, go to bed tired and wake up full of energy, fight and express anger, make up and hug, get presents and feel happy, and have things break and feel sad. Other toys, too, join the games, with all activities carrying an emotional content to talk about: a girl with a broken doll, a boy licking ice cream, a baby crying in its crib.

These supposedly simple activities teach particular routines even as they help build within the child the neurological networks that hold (i.e., internalize) such schema and enable the child to use them independently. These neurological pathways are often well-formed by early toddlerhood as children employ reciprocal communication to communicate, as well as explore the world around them (Cozolino, 2006; Levine and Kline, 2007; Perry and Szalavitz, 2006; Stien and Kendall, 2004). Though seemingly infantile for a child in grade school, such simple schemas can be a crucial part of filling up "communication holes" for children who did not have the opportunity to develop them earlier.

As we work, I offer Leroy opportunities to experience nurturing while strengthening concrete connections between body and sensation, and action and result. I offer him cookies and milk, and comment on their taste, and how they help satisfy hunger and slake thirst. I ask him to help dress toy figurines, put them to bed, or bandage the stuffed tiger's knee. At first bewildered, Leroy nonetheless complies and gradually starts to use some of the language I have modeled in related pictures and story contexts. He still cannot quite comment about his own body-states or emotions, but he is learning.

Several times when I come to see him he is in a combative mood or crying. I narrate to him what it seems to me he might be feeling, reassure him of his safety with me, and bring up situations that make me feel such feelings. I narrate what makes me feel sad, or angry, or confused. I do the same when he looks pleased, or happy, or proud. General classroom situations become fodder for discussing feelings he likely experiences: anger, fear, confusion, embarrassment, frustration, and occasional accomplishment. I teach but do not confront Leroy on his amnesia to incidents in the classroom. I do not try to pry into the underlying causes. This is not my goal, and it is not my place to do so. Not when amnesia often plays a protective role.

Raising red flags with staff and teaching emotions and body sensations are well within my responsibility, but probing into protective skills is beyond my scope of practice. Leroy needs to receive psychotherapy with a trauma specialist who would help him process traumatic experiences, whatever they might be. Just as importantly, it is crucial not to dismantle protective defenses until a child is in a safe place in all aspects of his life, or I would be taking away a defense the child still needs (Herman, 1997; Perry and Szalavitz, 2006; Shirar, 1996; Silberg, 1998, 2013). This caution is especially important because I do not know enough about Leroy's current circum-

stances and can therefore only offer supportive therapy. By creating a place of safety with me, I am allowing some reparative experiences, and, by giving him better language, Leroy will hopefully have tools to use when he finally does receive counseling.

As part of learning more about Leroy, I ask his teachers to complete the Child Dissociative Checklist (CDC) (Putnam, 1997). It is a screening tool developed by Frank Putnam, a leading researcher and clinician in the trauma and dissociation field. The twenty-item checklist is meant to be completed by adults familiar with the child and involves marking the presence or absence of certain behaviors and their frequency. Mrs. Tibo and Ms. Linda qualify as familiar with Leroy and are happy to complete it, exclaiming as they do, "Yeah, he does that" and "Wow, that's so totally Leroy!"

The CDC (Putnam, 1997) is helpful not only for getting information from caregivers, but also as a way to raise their awareness to behaviors they might not have given much thought to before. Most teachers are pleased to be asked to provide input about a child and their observations of the child's behavior.

Dissociation is usually prompted by trauma, abuse, or neglect. Leroy's file says nothing about direct past or present trauma, though the neighborhood he lives in raises the likelihood that he had been exposed to some (Silva, 2004). It is possible he was never personally abused or neglected but has witnessed violence—a trauma that is seldom included in the history given to school files (which are often incomplete even of references to direct trauma a child survived). Witnessing trauma without having support and soothing to manage it may necessitate dissociative protection. It is also important to recall that what might overwhelm one child may not overwhelm another (Herman, 1997). A significant score on the CDC could prompt an evaluation by a mental-health professional in the trauma field who can then help figure out why the child employs dissociation and how to resolve the trauma.

I am not surprised when Leroy's results put him well within the range for dissociation—he scores at 19 (the cut-off for likely dissociative symptoms being 12 or above). Going through the list, random behaviors come into meaningful focus: Leroy has frequent trances and daydreaming, he is unusually forgetful and confused, has poor sense of time, and has marked variation in skills and knowledge. He has difficulty learning from experience or appreciating consequences, and denies behavior even in the face of evidence. He has intense outbursts of rage during which he shows

unusual strength. He talks to himself and has rapid personality changes. He regresses from age-level behaviors and shows unusual sexual precociousness. Leroy's behavior has all the indicators of a highly dissociative child.

Whatever caused, and might still be causing, Leroy to dissociate, I want to help him manage better, including helping his teachers to understand him and respond in a more supportive way. In other words, I want to help minimize, not exacerbate, his symptoms.

I schedule a meeting with the teachers over their lunch period while the children are in art class and explain the results of the CDC. Mrs. Tibo comments she was surprised completing it. "I never thought about it all together, you know, but he certainly has a lot of these behaviors, whatever you mean by dissociation."

"It is almost like he is two children," Ms Linda hesitates. "Or more. You never know what's going to set him off and get all different on you. . . . It's kind of spooky sometimes."

Mrs. Tibo nods.

I explain the basics of trauma and trauma responses. Whenever we are exposed to an event that is overwhelming, over which we have little control, and that we perceive as threatening to harm us—the "recipe" for a traumatic scenario—dissociation is a likely coping response. It provides a way to cope with overpowering fear and helplessness by distancing those feelings from awareness, essentially making the traumatic event feel not real or less real, as if it is not happening to us or, at least, is not so painful (Herman, 1997; Putnam, 1997; Nijenhuis, 2004; van der Kolk, 1987). It is really an amazing coping skill that helps people get through otherwise unbearable experiences.

"I know what you mean," Mrs. Tibo comments. "My son was in his little seat behind me on the bike when we fell. I knew we were falling and couldn't stop it and it felt like a movie . . . in slow motion . . . I was so scared for him I didn't even notice I needed stitches." She lifts her sleeve to show a jagged scar on her arm. "Didn't feel any pain until I knew he was okay. I was so focused on him."

"Exactly," I confirm. "At that time it was helpful for you not to feel your pain so you could focus on your son. You dissociated from the physical pain, and it was a good thing you could. The problem arises," I explain, "when dissociation continues and dissociative responses are applied out of habit in situations that aren't threatening: if you kept being numb and didn't get care for your injury, or if seeing a bike now made you feel unreal or terrified. You can say that someone is experiencing problematic dissociation when it interferes with, intrudes on everyday life" (Herman, 1997; Steinberg and Schnall, 2000; van der Kolk, 1987).

"So dissociating is normal as long as you do it at the right time?" Mrs. Tibo asks.

"Pretty much . . . we all dissociate sometimes and not all dissociation is abnormal or even trauma related. Normal dissociation can be

pleasurable—getting involved in a movie, daydreaming, becoming immersed in something. In some way it is a matter of degree. Normal dissociation is pliable—we can shift easily from our 'spaced-out' state back to everyday awareness and don't lose awareness of who we are or what is going on."

"But what about the trauma reaction thing?" Ms. Linda asks. "How is that different?"

"Trauma responses are also on a continuum. Not all responses are dissociative. Your heart might beat faster but that's not a dissociative response. But not feeling pain of an injury or feeling as though you are observing something from afar would be. If something reminds you of an unpleasant situation, you might react to it or have feelings about it but still know where you are and what's going on in the now—you are aware of what is going on and why. That is a trauma reaction. A dissociative response might be to be 'transported' right back to the trauma, so much so you might not know that it is no longer happening—in effect, dissociating from the present time and reality. Another example, when sirens blare, I startle. I grew up in Israel through wars and terror-bombing, so sirens are hard-wired into my inner alarm. My heart speeds up before my brain kicks in and I notice it is a regular siren, not an attack warning. I might be reminded of earlier events but I don't get completely lost into them, just distracted momentarily from what I'm doing. Someone who was traumatized and used dissociation to manage the trauma might get triggered to an earlier experience and respond as he did then—dissociating—not recognizing it is 'now' and he is in a safe place."

The teachers nod.

"So you are saying that Leroy was traumatized," Ms. Linda states.

"I don't know," I reply. "Given his responses, I think it is quite possible, but this doesn't mean I know for sure or know how. We don't always know what happened to children who exhibit posttraumatic symptoms. Students' files are often skeletal. Also, many events that can be traumatic for a particular child are rarely thought of as such, so they're not recorded."

"Like what?"

"Children can and do react posttraumatically to things such as a parent's chronic anxiety or depression, to witnessing violence on the street, to being homeless, to harsh discipline, even to their parent's own traumatic stress—especially if their parents are chronically scared or scary. Children have so little control over their world and are so completely dependent on the adults in their life, that an overwhelmed parent who explodes is terrifying; and an overwhelmed parent who is unavailable to support them leaves the child in a frightening place without access to being soothed. Children can also react posttraumatically to witnessing domestic violence and to painful or scary medical procedures (Herman, 1997; ISSTD Child and Adolescent Committee, 2008; Levine and Kline, 2007; Silva, 2004).

"But every parent gets overwhelmed." Mrs Tibo protests. "That would make all the children in the world traumatized."

"That's an excellent point. Even if a parent is overwhelmed and explodes, or ignores the child to the extent that the child gets very scared, there need not be trauma, at least not if the parent is able to soothe the child. If the parent explains what happened and reassures the child that she or he—the parent—is ok, and the child is ok, the child can actually learn positive lessons. They can internalize that they can rely on their parents to soothe and care for them, thus the feeling of helplessness is temporary. The problem is if a parent is unable to comfort the child or doesn't even recognize that the child is upset. The child might be left with overwhelming feelings without help in managing them and might need to deal with it by 'checking out.'

"Managing trauma is even harder for a child when it is directly caused by the caregiver . . . because it leaves the child with no one to go to for comfort. Whether it is intentional, such as in physical or sexual abuse, or unintentional, as with neglect due to a parent's mental illness or addictions, the child can't rely on the adult to soothe them because the adults are the ones hurting them!

"Some children are neurologically and psychologically more sensitive than others. They can become overwhelmed and flooded by things that another child can manage better (Denham, 1998; Osofsky, 2004, 2011; Perry and Szalavitz, 2006; Stien and Kendall, 2004). Add trauma to their experiences and you have a recipe for dissociation. Then, there's cumulative stress: think of how many of our students live with foster families, often in multiple placements, or are 'crack babies' with already overwhelmed nervous systems. Some have documented histories of abuse—all are high risk for dissociation."

"So what do we do?" Mrs. Tibo asks. "Let's say Leroy was abused or had traumas. We still can't let him do whatever he wants just because he gets upset!"

Mrs. Tibo's question is a common one. Teachers are often empathic for students' plight but need concrete solutions for keeping things manageable in the classroom. Just knowing about dissociation or why the child is "misbehaving" is not enough. Teachers need to have tools: to minimize a child's need to dissociate in the classroom by determining what the child needs in order to feel safe in the classroom; to recognize when the child is dissociating; and to know how to respond helpfully so the child becomes grounded back into the classroom and can do the work. Children spend most waking hours in school. Meeting with teachers is essential to working with the child and establishing a supportive environment. (For more information about recognizing and managing dissociative children in the

> classroom, check the frequently asked questions [FAQs] for teachers on the website of the International Society for the Study of Trauma and Dissociation [ISSTD]: www.isst-d.org/default.asp?contentID=100.)

Several other teachers have entered the teachers' lounge as we talk. A few join our table and add their experiences with Leroy and other "problem children."

I share with the teachers how helping a dissociative child in the classroom and managing dissociative episodes can help the episodes be shorter and milder.

"One thing that isn't helpful," I say, "is to confront a child about a behavior when he is dissociating. For example, if a child is reactive to a loud sound and 'freezes'; raising our voice in an attempt to 'get through to him' can scare the child further, thus increasing the child's use of dissociation. Similarly, roughly restraining or grabbing the child (unless in an emergency, if we must protect him or others), often leads to exacerbation of the dissociative state (aggression or withdrawal).

"Also, even though it can be really frustrating to have a child denying something he just did, labeling the child (rather than the behavior) as 'bad,' 'liar,' etc., can feed into how awful the child already feels about himself. For a child with a history of, say, emotional abuse, such comments by the teacher may become a trigger for reliving earlier distress. It is important to remember that a child who dissociates might have amnesia for (i.e., not remember) what the teacher is referring to and truly feels unjustly accused.

"Given how triggers can cause or increase dissociative responses, it is usually helpful to know what triggers a specific child. Some triggers will be closely related to the child's trauma (for example, seeing a baseball bat for a child who witnessed a beating with one). Other triggers might be vaguer (for example, time of day when something bad happened, a tone of voice that reminds the child of someone or something)."

"So how am I supposed to know what would trigger each child?" Mr. Kay, the gym teacher, joins in. "I won't be able to do anything because everything will potentially trigger someone."

"That's where having background information is helpful. For example, if you know a child survived a house fire, it will help you understand why every time there's a fire truck around, she freezes and spaces out, or becomes upset."

"How would I know if the child is really dissociating or just being difficult? I don't want it to become an excuse for bad behavior. Some children know how to be really bad."

"Yeah," Mrs. Tibo adds, "and I don't want the other children to learn that it is okay to misbehave, either."

The other teachers nod an affirmative.

> These are frequent and fair concerns. However caring teachers can be toward children in distress, they do not want to be taken advantage of. Children can be manipulative and test boundaries, and teachers want to know how to differentiate the child who needs discipline from the child who needs support—especially when it is often the very same child. Teachers also worry about peers using the misbehaving child as a bad example of acceptable behavior.

"This is a really good point," I confirm. "Personally, I find it better to err on the side of caution. In a child who has known trauma or is dissociative, I'd consider dissociation as a first explanation to a behavior change. This doesn't mean there'd be no consequences for misbehaving, but that a different approach can be taken to address the behavior. I will want to consider what could have caused the child to misbehave and help the child get grounded before requiring a consequence."

The assistant principal pokes her head into the teachers' lounge: "Fire drill, ladies, Mr. Kay, five minutes!"

We scatter to the different classes, and I go along with Mrs. Tibo and Ms. Linda. Speaking of triggers, Leroy hates the shrill fire-drill bell (same as in my office) and has been known to "ruin" the drill for the whole class by turning violent, or refusing to budge and delaying everyone. I would like to assist him—and the teachers—in getting through the drill with the least dismay possible. As we rush through the hallways, I narrate my plan: I will tell Leroy what is coming, reassure him that he is safe with me, stay with him through the drill to see he does not get too overwhelmed, and then go over the event with him to make sure he knew what just took place.

"Sometimes, we don't know in advance what can upset a child," I add, "but here we have an opportunity to prevent or at least minimize the reaction that overwhelms him."

The children are gluing colorful feathers and foam-shapes onto construction paper. The theme seems to be hues of colors: one child's page is all in reds, another all in purples, a third in yellows. Leroy's page looks as if it is started as a composition on blue but turned into a splatter of any color he could get his hands on.

I pull up a chair and explain to Leroy that there is going to be a very noisy bell in a moment but that it will only be a fire drill. "There is no fire, Leroy," I emphasize. "It is an exercise. Just practice. This way we can get very good at getting out of the building in case there ever is a fire."

He nods absently.

"Leroy, I need you to look at me. I know you want to continue with your beautiful project, but right now it is important you listen. Can you please look at me?"

It is helpful to establish a connection with the child (e.g., acknowledge what he is involved with) before attempting to move the child to doing something else. This helps put the child's current activity in context, as well as validates that the child's experience is important (even though he might still need to interrupt it). This provides a connection between the adult and the child, and confirms that the adult is interested in and attuned to the child's feelings and needs.

He frowns, but dutifully raises his eyes to me.

"Thanks, Leroy. There's going to be a very loud bell in a moment. It will ring three times. We're going to count three bells and then you are going to give me your hand and we're all going to walk down the stairs and out of the building. Everyone will be going out the building. We need to walk quietly and listen to what the teachers are saying, ok?"

"I doing art," he states.

"I know, Leroy. You can continue with the art project after the fire-drill is over, but for now you need to stop and follow directions during the drill."

I barely finish my sentence when the first bell rings. The boy starts violently and looks at me wildly.

"Leroy, it's okay. It is the fire drill I told you about." I say in the moment's space between bells.

The next bell jars and he stiffens, his head swivels around, and he blinks rapidly.

I offer my hand and he clings to it. "This is the second bell, Leroy. There's going to be one more."

I can feel him shaking. He stays rooted even as the third bell stops clanging and the other children begin to file by the classroom's door.

"Everything is okay, Leroy," I affirm, keeping my voice calm. "This is a fire drill and we're going to walk down the stairs and out of the building. Nothing bad is happening. You are safe, and I'm right here with you. This is just a fire drill. Just practice. We're going to walk together, ok?"

He is still shaking, but he nods and walks with me. I keep a slight distance between him and the boy in front of us. Leroy is especially jumpy when he is anxious and he can easily interpret a casual touch as an assault.

Most of the children chatter excitedly, unheeding the teachers demand for quiet, but Leroy walks in silence, his body tight as if it can snap at the slightest touch. I can see his heartbeat thrumming in his neck.

When the brain perceives danger—triggered or actual—it activates an enormous energy in response which results in physiological reactions that prepare us either to fight (i.e., increased heart rate and blood flow to the

large muscles, increased tension in muscles ready to spring, fast respiration, pupil dilation, decrease in verbal ability, etc.) or alternatively to freeze as muscles collapse and the organism shuts down in overwhelm (Levine and Kline, 2007; Perry and Szalavitz, 2006; Stien and Kendall, 2004). Children who are triggered often present as teetering on the edge between explosion and shutdown.

"It's okay Leroy," I say softly. "Nothing's wrong. It is just a fire drill. We are at school and everyone is going down the stairs. You are safe here with me, Miss Y. Everything's okay."

"Okay?" he whispers.

"Yes, Leroy, everything's okay . . . we're just walking out for a moment and then we'll come back in and you can continue your art work."

We make it out of the building without incident, join the snaking line of children around the block, and suffer the (somewhat justified) critique of the principal for how long the school's evacuation took and how noisily it was executed.

Soon enough the signal to return is given, and the children turn on their heels and walk back in. As we enter the building, Leroy seems to shake off his wooden anxiety. He bounces around and pulls on my arm. The teacher looks at me in alarm—Leroy is just as problematic when he is in one of his "excited moods," especially when he "wakes up" from being upset. I nod in reassurance and point to his sticky hand in mine. "We're practically glued together," I mouth and she chuckles.

"Leroy, look around and see how everyone is walking nicely. I need you to walk nicely, too. We're going back to the classroom and you can continue with your art project."

"Where we going? I doing Speech now?" He looks baffled, like he does not remember what just took place and why I am with him in a school hallway, holding his hand.

"You were working on an art project with feathers and colors. And glue . . ."

His eyes wander down to our hands, a questioning expression in his eyes.

"Yeah, we both have glue on our fingers now. We had a fire drill and had to go outside for a moment. Now we're going back to the classroom and you can finish your project."

"Art?" He asks, suddenly comprehending. "We doing art now?"

I nod and hum affirmatively.

He tugs on my arm and calls to Ms. Linda, who is a few steps ahead of us, walking alongside the rest of the class. "Miss Linda! Miss Linda! I going to art now! I had a fire drill and I going to art now!"

She smiles.

When I see Leroy's teachers again the following week, they tell me that they have made a list of some things they recognize can trigger Leroy: children touching him (apparently more so when they touch his shoulder, head, or back), loud noises, changes in routine, hearing another child cry, making a mistake. They do not see how they can prevent other children from occasionally touching him, or from crying, or an outside noise. However, seeing how well he did with the relatively simple preparation for the fire drill—the first sudden transition without a meltdown—they wonder if they can prepare him better for transitions in the classroom.

Borrowing from techniques often used with children with autism spectrum disorder or cognitive disabilities, we make picture cards to represent different school activities, and place Velcro bits on their backs. I recommend that at the beginning of each day, they go over the day's planned events and have Leroy stick the activities on a felt board in the order of their schedule. They may try reviewing every transition a short while before it takes place, so that he will have time to process it before the actual demand to shift activities. For special events—a class trip or a show at the school's auditorium—they can go over the changes with him the day before as well as in the morning, so he is better prepared. It could help to ask him to repeat the schedule after them, pointing to the cards as he does. This will help Leroy verbalize the sequence and allow another layer of processing to take place.

In Speech, I reinforce this technique by working on identifying activities in stories and putting them in order to make sure that Leroy understands what each school activity involves and the vocabulary that accompanies it.

In all of us, dissociative-type responses stem from fear, rage, shame, helplessness, loss, confusion, and other difficult emotions (Herman, 1997; Nijenhuis, 2004). We rely on our understanding of how things work and what we can expect to happen next, to help us feel less out of control. By preparing a child for events that could evoke difficult feelings, the child can be less startled by those events, and feel less helpless and scared.

Helping prepare the child also lets the child feel that his or her feelings are understood and responded to. A child who feels taken care of feels less afraid, is less on-guard, and therefore will have less need to call on dissociative defenses.

Teachers are often familiar with interventions such as Leroy's picture-schedule, and are comfortable using them because they fit within their skills and knowledge. It is an intervention that can easily be generalized to the rest of the class without singling out one child, another aspect that teachers often find important.

The teachers and I discuss what to do if Leroy gets overwhelmed in spite of these precautions and what would help most in the class setting. I recommend that they respond gently and remind him he is safe, who they are, where he is, and that nothing bad is happening (even if they cannot perceive any danger and think he ought to feel safe without them saying so). If he misbehaved, and even though the misbehavior needs to be stopped immediately, it is best not to confront him right away but to wait until he is more present and in a calm state.

"Many times his behavior escalates when he feels criticized and punished," I say. "I think that maybe once he has experience with your voice helping him get calmer, he'll be more responsive because he won't immediately assume that you are going to punish him."

> Calm is the antithesis of overwhelm. When soothed, the autonomic nervous system reaction dials down, and the child is less likely to dissociate. Internalizing an association of soothing (e.g., a fussy baby calms at the sound of his mother's voice even before she picks him up) helps the child avoid dissociation; and if dissociated already, this can help anchor the child into the present, and reduce the duration and severity of the dissociative response (Bowlby, 1997; Cozolino, 2006; Levine and Kline, 2007, Silberg 2013).

Both women agree to try responding differently to Leroy's outbursts, though they are clearly wary of what seems to them as reinforcing his bad behavior by "being nice to him when he deserves to be punished."

"Once he's calmer, he'd be much more willing to listen to what happened and why he has a consequence to deal with," I stress. "I really believe he wants to understand, but when upset, he isn't processing anything you are saying and is only focused on the perception of 'being accused' and/or the feeling of being a bad person."

> One of the responses of the brain to stress is to flood the brain with stress hormones (e.g., cortisol) that are meant to prepare the body for a possible assault. This flooding, however, affects the ability of the frontal lobes and the hippocampus to process and organize information, and temporarily reduces verbal ability. An overwhelmed child often literally cannot process what is said to him until his neurophysiology is calmed down (Levine and Kline, 2007; Perry and Szalavitz, 2006).

Over the next few weeks, the teachers report that Leroy is having fewer explosive episodes. They talk to all the children about body boundaries and respecting how some children do not like being touched or leaned

against. That helps, too. Leroy enjoys lining up the activity cards each morning, and some days he is able to do so by himself from memory—a major achievement for him. When prompted by a teacher, he usually quite agreeably refers to the board to see what is coming next.

One day, a music teacher entered the class unannounced and Leroy rushed to the board, scanned the day's cards, and shouted, "No music today!" When Mrs. Tibo told him that this was a last-minute change, he paused, thought about it, then selected the music card from the envelope below the felt board and rearranged the day's cards to accommodate the music card in the correct order. He was still glowing with the praise he received for this when I came to see him the next day, and looked touchingly proud when Mrs. Tibo told me how well he did.

Both Mrs. Tibo and Ms. Linda admit having to be less creative than they thought they would have to be to find things to praise Leroy for. There are now good behaviors to praise.

"He's really trying," Ms. Linda tells me one day, "and it makes it easier to be kind to him." She blushes. "Not that I didn't care about him before—because I did, only I think I like him more now."

One of the most helpful things for Leroy is probably that the teachers feel less helpless to help him, which allows them to be more compassionate toward him and results in him feeling more lovable. Children are acutely aware of the adults around them, and Leroy, for all his fury and aggression, craves approval and affection just like any child, and quite possibly more. His gains in positive behavior are likely not only due to the new routines and increased predictability, but also due to the improved attachment in his relationship with the teachers (Kagan, 2004; Pearce and Pezzot-Pearce, 1997; Terr, 1990; Wallin, 2007). By making the classroom experience calmer, not only did Leroy become calmer, but the teachers, too, are less on edge and therefore less scared/scary.

Leroy is doing better overall, but he still quite regularly explodes and attacks, hits, swears, and spits. The list of probable triggers grows: the bark of dogs, anyone cutting in line before him, the mention of fathers or birthdays, and bits of torn paper on the floor. Though helpful, this list is only for connections made in hindsight (i.e., after he has reacted to them negatively). I remind his sometimes exasperated teachers that hindsight is valuable because it allows better handling of a trigger in the future.

At one point, Leroy spends a full hour on his back, hands over his ears, screeching in rage and feet in kicking motions in the air. It is not one of my school days, so I only hear of it the next day. Apparently the security guard had to come haul him out of the classroom and to the principal's office, where his grandma was called to come take him home.

"The strange thing is," Mrs. Tibo tells me, "it was almost like he had an 'on–off' button. The moment Mr. Brown (the security guard) grabbed him; he clammed up like someone turned him off. I swear it was strange. He didn't even fight like he would with me or Ms. Linda, just turned totally silent, like a stone. I still don't know what ticked him off in the first place—one minute he was sitting in his desk and the next he was flying to the floor, screaming like a banshee."

I look at the boy. Nothing about him belies the events of the day before.

"I didn't ask him what happened," Mrs. Tibo adds. "Didn't want to raise demons, if you know what I mean—as long as he's quiet, why bring up yesterday?"

Mrs. Tibo's hesitation makes sense—this is why it is so crucial that the boy be in therapy. Without knowing what a child's dissociative defenses are about, and without assuring safety in all aspects of the child's life so these defenses can be addressed, there is only a limited relief that can be achieved. While crucial for improving the day-to-day life of a dissociative child, grounding and ego-strengthening alone are not sufficient. Therapy would be the right place to explore what happened and why.

It is upsetting to me that I was not there, not only because my heart breaks for how awful Leroy must have been feeling and for how scared he probably was when the security guard plucked him up (it appears he shifted into another dissociated state when the security guard came to get him, and that was why his behavior shifted so dramatically), but also because maybe I would have managed to help him get himself grounded enough to prevent him being removed bodily (and thus triggered further), something that is not likely to help make the classroom feel safe.

(As I explore my own feelings, it helps me to become aware that some of my upset is rooted in my own protective feelings toward Leroy and my frustration at his situation—how it might have been an opportunity to drag the psychologist in to see Leroy "in action" so he could be convinced to recommend counseling.)

A Teacher's Toolkit

Leroy's intense "tantrum" (the school's official view of the event) brings to the forefront the teachers' need for more concrete ways to help ground him when he is overwhelmed. One of the things I found helpful with Leroy is to tell him—in a calm voice—to take a deep breath, then take one with him. While not a magic pill, taking a deep breath can help calm the neurological system (Levine and Kline, 2007) and can help Leroy curtail

some of his explosions. Reminding him to breathe is occasionally enough to help reorient Leroy to the present, so he can actually listen to what I am saying.

I show the teachers what I mean by modeling deep breathing, and we practice a few times. However, they are uncomfortable with the role-playing, and I am not optimistic that they will use "this breathing thing" with Leroy. If they are uncomfortable with the technique, it is not likely that Leroy will perceive it as comforting, either. Nonetheless, I ask them to consider it a backup intervention.

Another tip I model to the teachers is to hold my hand palm down in front of my body (not too close to his face so as not to spook him) and move it gently downward a few inches in a "calm down" motion. Leroy often follows the motion of my hand, and takes a deep breath even if he does not seem to be hearing what I am saying or asking him to do. The teachers are considerably more comfortable with this cue than with the breathing—they use several hand signals in the classroom on a daily basis already.

To help reinforce the hand-motion cue, I practice it with Leroy in our session. I explain to him what it means and how it can remind him to calm down, even when his mind is too busy to listen. I have one of the stuffed animals "get really angry" and then prompt it to calm down and "it does." It is then Leroy's turn to "calm" a series of toys having tantrums and—best of all—to "help me calm down" when I pretend to get really upset. He loves the new "game."

When I ask him, as review, what the hand motion helps him do, he pauses for a moment then says, "It make it more better in my head and I see you."

> This is the first time Leroy has ever referred to his experience during the times he rages or loses control. If he were in psychotherapy, it would probably be an excellent thread to follow to find out more about the "in my head" experience, to explore what "better" means, what it is like when it is "not better," and so forth. However, given that I do not want to move beyond the scope of the clinical work I am trained and licensed to do, I make a note to myself of his expressed insight and focus on continuing to expand the range of Leroy's grounding tools.

"That's really good, Leroy," I comment. "Are there any other things that you think can help make it better in your head?"

He looks startled. Not exactly scared but surprised at the inquiry. I have seen this reaction before in many of the children I work with: they are very rarely asked their opinion. Their lives are full of directive language but little chance to consider and express their ideas.

"Um . . . umm . . .," he thinks, fidgets. Then purposefully snuggles up to me, leaning his head against my arm. "Like that," he says, snuggling closer until his head finds a comfortable niche.

"That helps?" I half-ask, half-comment.

He nods noncommittally and just sits still for a moment or two. I have a feeling he is not "done" and simply wait with him. He shortly jumps up from his chair to grab a stuffed bear animal and a Playmobil® character. He makes the doll have a tantrum (placing it supine on the table, twirling it, and banging it around). He often "plays" with toys this way, and though his handling seems more directed today, I still half-expect to see him "make them fight." Leroy surprises me. He takes the bear and very gently puts it close to the doll, then stops twirling the character and the doll "quiets down."

"You see?" he comments with satisfaction. "His head better now."

"Oh," I comment. My heart is so full I am at a loss for words.

> Leroy's ability to role-play as a way of explaining is stunningly important, especially for a child who lacked narrative and communicative tools, and had no words for physical and emotional states. His role-play demonstrates that he has internalized the concept of comforting turmoil (i.e., has formed neuronal pathways for soothing) and is able to express it by a combination of words and actions. As he expressed it, the concept would have become more organized internally and more real for him as well. As he was explaining how he felt to me, his body was relaxed, and he was focused and present. He was not acting out his feelings but communicating what his experience was like through the toys and with words. By using even those few words, he was starting to teach his body a new way to manage an experience—by talking about it instead of just reliving it or drowning in it.

Seeing how Leroy loves one of my plastic characters (a Playmobil® firefighter figurine) and how several times he seemed reassured by holding it, I get another of the same character for his classroom and ask the teachers to tell him it is there for him to hold whenever he gets overwhelmed. Mrs. Tibo is not enamored with the idea. She worries he would take advantage of this and play instead of study. She is also not pleased with the possibility of other children wanting toys at their desks. Nevertheless, she is willing to give it a cautious try.

Interestingly, Leroy does not ask for the doll very often. It is not clear if this is because he does not remember it is there, or because he feels reassured just knowing of the option to ask for it. Maybe because he does not flaunt it, the other students just seem to accept he needs the toy. In fact, one day when Leroy reportedly gets upset about a drawing not coming out the way he wanted and starts tearing it apart and tossing the

crayons on the floor, a classmate caringly recommends to Ms. Linda, "Maybe Leroy needing his firefighter now."

Giving a child a toy, or allowing a child to leave his or her desk for an area of the classroom in which the child feels safer, is often seen by teachers as coddling and even rewarding bad behavior, as they are often reluctant to single out one child—even more so when that child is prone to misbehaving. It is an understandable concern but, for children who are already disruptive to the class, these adaptations are worth a try. A child leaving his desk or handling a toy might miss some instruction and possibly disrupt the class momentarily, but if it helps the child remain less agitated, the child will likely listen better, as well as save the class the bigger distraction of a child in rage. Reducing the number of dissociative episodes can improve overall classroom management, and can build better connection between the teachers and child, and the child and peers.

When a child is in distress, teachers can utilize a six-step "toolkit" (ISSTD Child and Adolescent Committee, 2009):

1. *Grounding*: Helps a child reorient to the present. As soon as the teacher notices the child beginning to dissociate, the teacher can approach gently and let the child know where the child is and who the child is—not assume the child knows.
2. *Reassuring*: Lets the child know he or she is safe. Even if nothing outwardly scary is taking place, the triggered child might not know he or she is safe. Telling the child that no one is being hurt, that the child is safe in the moment, not being hurt, and is okay can help, as can reminding the child to breathe.
3. *Checking in*: Once the child seems more present, it can help to ask if the child is okay. Does the child know where he or she is and who the teacher is? The child might be reassured by an object associated with comfort (e.g., Leroy's firefighter figurine). A drink of water or a damp cloth for the child to wipe his or her face with can help sometimes, as well.
4. *Narrating/describing/putting in context*: Rather than asking the child what happened, it is best just to tell the child. The child may not remember, or may have a hard time putting it into words. If something happened in the school or classroom, it helps to describe it simply and without blame.
5. *Deferring blame/investigation/consequence until the child is calm*: It is important to refrain from using interrogative questions such as, "Why did you do that?," or "What got into you?" The child may not know. The child may not remember. Once the child is calm, it can help to

reiterate what took place. (The child might not have been able to process it earlier.) If misbehavior took place, calm explanation of cause and effect is important (e.g., "You pushed Cynthia, and when someone pushes in our class they get time-out, so please go sit in the time-out chair now."). It is best not to enter into an argument with the child if he or she disagrees, and to refrain from making general statements about the child's character (e.g., "Stop lying. You always do that."). Calm explanation that, even if the child does not remember doing something, or did not mean to do it, there is still a consequence to deal with, can help. It is important to be kind but firm.

6. *Providing safety for all*: The safety of everyone in the classroom is paramount, teachers included. If the child tends to be violent, a backup plan for assistance is important (in Leroy's case, they were to call me on the days I was at the school, or my colleague on other days).

I print the six-step toolkit on a sheet of cardstock and give it to the teachers. They smile indulgently and state that I might as well get used to being summoned to help them out because "Leroy listens to you best." I nod but tell them it is not really any magic I do that they cannot accomplish as well. In fact, I remind them, did not the routines they had already established help him be less explosion-prone?

We have a few weeks of relative bliss. Leroy is calmer. He has fewer outbursts and, when he does, he seems more able to regain his composure (become grounded). A few times Mrs. Tibo tells me that she "did the grounding thing and told him where he was," and he seemed to calm down a bit. On one occasion, he even went to the time-out chair without argument and sat there, holding his firefighter until called to join the class. Mrs. Linda was not sure that he "deserved" the firefighter at that time, but Mrs. Tibo reminded her it was not a reward but a grounding item for Leroy. I agree and point out that, even if it were a reward, maybe he actually deserved one for following the direction and going to the time-out chair without conflict.

In Speech sessions, too, Leroy is making progress. His ability to listen is improving, and he is better able correctly to label emotions in stories, or match cause-and-effect. He can narrate simple things he did in class, or tell me what he just had for lunch. He struggles less to remember classmates' names and no longer asks for mine. He is able to state some of his preferences—a favorite color, snack, or animal—things that he was unable to do before.

Is Leroy's progress a result of the reduced need to dissociate in school (i.e., an increase in his sense of safety), or a direct result of the speech therapy intervention he is receiving? Probably both, and I believe that neither could

happen without the other. By being less on edge at school, Leroy is able to remain more available to instruction in the classroom, and spending more time in the present, he can experience interactions that are both informative and positive.

Children learn by exposure. When they are absent from reality much of the time, their opportunities for learning are greatly reduced. In addition, during a dissociative episode, a child may be reliving and, in effect, reinforcing scary interactions or assumptions about life. The fewer the dissociative phases, the less those negative connections are reinforced.

Leroy's progress is real, but how significant is it? It is still highly bound to arranging his outside environment. Having better awareness of what makes him dissociate and gentler ways to help him ground himself, we reduce his external triggers and help him be in a place of safety. However, without skilled psychological treatment to help resolve the underlying causes of his dissociation and teach him ways to manage his stress better internally without dissociating, Leroy's improvement is limited. His progress in school is important; but not sufficient.

After months of runaround, Mrs. Tibo was given the opportunity to appeal her request for one-to-one classroom assistance for Leroy. I write a letter recommending it, though both the teachers and I are not optimistic. The psychologist as much as told us that he would not push for it, especially "now that his behavior is better managed in the classroom." Implying that now that the teacher is finally "doing her job," with class management, there is no reason for extra help because she no longer really needs it. Leroy's improved behavior is given as reason for denying counseling, as well. It is a double-bind: when Leroy was doing poorly, he was considered far too "bad" to be worthy of making use of counseling, and now that he is improving some, he is deemed not to need it. This, regardless of the fact he is still clearly struggling, and that much of the improvement stems from manipulating his environment to minimize his outbursts, not because his underlying difficulties have resolved.

The denial is infuriating, especially given additional information that came to light about his early childhood experiences—Leroy lived in a household where domestic violence was rampant, and as an infant and toddler both witnessed and suffered from the violence. It feels to me as if Leroy is penalized for working hard to behave better.

When the early trauma history is raised, the psychologist calmly states that "these alleged things happened too long ago to give them much attention now—the boy needs to look forward, not dwell on the past. Not like he is being abused now."

"What I mean," I say slowly, forcing myself to breathe, "is that I am not sure what would qualify in your eyes as a sign that the child is in distress.

We have a child who is hypervigilant, responds with disproportionate alarm to stimuli, behaves in ways that are alternately terrified and aggressive, has periods of amnesia, displays fluctuating abilities, and has many other posttraumatic and dissociative indicators. A child we know had trauma in his history and is still exposed to stress and reminders of his trauma through the custody battle between his mother and grandmother."

"Did you see any signs that the child is being currently abused?" he interrupts. "Any bruising, scars, dressing inappropriate for the weather—any of the known signs of child abuse beyond your psychological theories?"

I try to convince myself he is simply ignorant, not malicious. It helps me keep my voice down. "Trauma signs involve more than just physical presentation. There are—as I am sure we all know—emotional and psychological indicators as well."

"In any event," I continue, pointedly ignoring his dagger-eyes, "I didn't say we need to call Child Services about a minor in danger. I meant he seems to be suffering from earlier trauma exposure and that counseling may help him. I thought that was what counseling was for."

The assistant principal steps in. "I am sure Dr. B will review the notes again and see if anything was missed on the counseling end. Now, unless you have a request regarding his speech mandate, Ms. Yehuda, I suggest that we move on."

Dr. B nods imperially. Mrs. Tibo gives me a knowing look. Neither of us will be surprised if his "review of the case" takes the rest of the school year, if he follows up on it at all.

Turf wars are common in the educational system. Unfortunately, when egos (and frustrations—as mine clearly did) get in the way, positions can be dug in. My intention was to lobby for Leroy, but my confrontational approach only antagonized the psychologist. He might be uneducated in trauma and uninterested in knowing more, but highlighting his ignorance was not helpful. Not only did I fail to help Leroy get the counseling he needs now, I might have shut the door on him getting it as long as this psychologist sees the boy as a reminder of his lack of knowledge.

Many education personnel are not currently knowledgeable about trauma. Some—for whatever reason—fear or resist learning about it. It is important to negotiate this landscape with care and gentle determination. In Leroy's case, I dropped the ball. Not so much in the truthfulness of what I said or my right to say it, but in how I said it.

Trauma education is important for all child-professionals (and school psychologists), and especially for speech-language pathologists, who are often the first to see a child who is failing at school and are called to determine whether a child's failure reflects low ability, lack of support at home, a learning disability, or something else (e.g., a trauma response).

Speech-language pathologists can then recommend additional assessments and intervention. Hopefully, trauma studies will soon become part of formal education for all educators and clinicians, particularly those working directly with children.

It is March and parent–teacher conferences are around the corner. I hope that Leroy's grandma will come, as I would like to hear how he is at home and more about his history, extended family, what he does on weekends—anything, really, beyond the bubble that is school. I leave a voicemail, encouraging the grandmother to come and hear about Leroy's progress in Speech and Language, but Mrs. Tibo cautions me not to hold my breath. No one showed up last year and, indeed, no one comes this year, either.

I am especially sorry she did not come when I learn (from one of the Lunchroom Matrons, incidentally) that Leroy was not always an only child. Like everything else in his history, the details are sketchy. It seems Leroy had a brother—only about a year younger—who died in some household accident (though the matron whispered that there were many who suspected it might have been avoided if the mother supervised the children better). It is not clear what exactly happened to Leroy's sibling. Was this why his mother lost custody? What seems undisputed is that Leroy—almost 4 years old at the time—was present when this happened. The boy was not attending school yet, but the Lunchroom Matron, who lives in the same housing project as both the grandma and the mother, reported that Leroy was very "strange" after that. He "started peeing his pants again" and "was twirling around, all autistic like, you know . . . like he was crazy or something."

The Lunchroom Matron states that the grandmother keeps to herself and does not speak about either grandson—the living or the dead. "You know," she adds, shaking her head, "she had a hard life, with her husband dying in construction and raising her kids alone and now the trouble with her son and having to raise her grandson . . . and him not being an easy one to raise, if you know what I mean."

"It is no wonder that he isn't," I add gently. "It sounds like he's had a hard life, too."

The woman tucks stray hairs under her hairnet and sighs in empathy, "Yeah, he sure don't have it easy, poor thing. Always pulled in two pieces between his momma and gramma . . . all them fighting . . . and his dad beating up on his momma and going to jail and all . . . and seeing his brother, you know . . . No wonder he acting up."

I could not agree more.

I do not know what exactly happened to Leroy's brother, what Leroy saw and understood, and whether he got support following what must have been an overwhelming experience. However, his subsequent behaviors certainly

indicate a child displaying posttraumatic symptoms, and with the cumulative traumas of instability at home, loss, violence, and continued conflict, Leroy's need for dissociative defenses seems understandable—reasonable, even.

I already knew his mother had supervised visitations, but it did not occur to me that she lived so nearby. How often does he run into her? What is it like for him to see her and not live with her? What does it mean to him that after his brother died everything changed for him, too? How often is he privy to the conflict, and reportedly vile and angry language, between his grandmother and mother? Does either take frustration out on him? I certainly suspect neither helps him with his feelings. Is it a wonder, really, that he is aggressive and easily startled, that he has difficulty putting sensations into feelings and words? Processing new cognitive and verbal information (the hallmark of social and school interactions) depends on a relative state of calm—something he rarely experiences. How can such a hypervigilant child listen, learn, recognize emotions in himself and others, and participate in play?

Leroy displays dissociative symptoms in his behavior and his communication. His communication profile is similar to that of other children who have trauma histories and who show dissociative features: in addition to small vocabularies and low school performance, maltreated children (many of whom dissociate) tend to lack state-descriptive language and to give ambiguous responses to emotion-evoking pictures. Traumatized children have deficits in discourse and are generally passive in their communication (responding rather than initiating) (Attias and Goodwin, 1999; Pearce and Pezzot-Pearce, 1997; Putnam, 1993, 1997; Yehuda, 2005). A great deal more research into communication and dissociative disorders is needed before we can identify symptom-clusters in language patterns that point to high probability for trauma and dissociation. However, we already know that traumatized children tend to have simplified repetitive play, cause classroom disturbance, have poor ability to maintain attention and involvement, and exhibit aggression and social incompetence (Pearce and Pezzot-Pearce, 1997; Putnam, 1997; Silberg 1998, 2013). More research is needed to pinpoint dissociation-specific communication issues (Yehuda, 2004, 2005).

Leroy also shows perseveration-like behaviors, periods of altered behavior, auditory memory issues, and amnesia—symptoms that can occur in children with neurological issues (e.g., closed-head injury, seizure disorders, etc.). Maybe Leroy's neurological-like symptoms can be a foot in the door for a comprehensive workup. Maybe a pediatric neurologist would succeed in recommending counseling where I did not. The risk is, of course, that if Leroy gets referred to someone who is blind to trauma, he might end up with even more diagnoses he does not have, or medications he might not need.

The school nurse is a mild woman with whom I had little contact. She listens carefully to my description of Leroy's symptoms, and agrees to speak with his teachers and follow up with a memo recommending a referral for a comprehensive evaluation. I am glad, because the district office supervisor confirms that such a memo is not likely to be ignored.

I have another meeting with Leroy's teachers. The gym and art teachers join us. They, too, have been using some of the grounding techniques with Leroy and are seeing positive (if limited) change.

Mr. Kay, the gym teacher, wants to know what to do when Leroy starts yelling about beating to a pulp. Should he ask him anything? Inquire as to what it is about? Ask where he had heard that? A bear of a man, the gym teacher is well-loved in the school, and his gruff exterior and no-nonsense attitude hide a very kind heart. He finds Leroy's distress upsetting and admits that he is torn between wanting to know more and not wanting to "open up stuff I won't know what to do with later."

The other teachers nod. I reply that it is indeed a fine line, and that I wrestle with similar dilemmas myself, especially when a child is not in therapy and there is no counselor to share impressions with or seek advice from. Speech-language pathologists and teachers do not—and should not—delve into trauma. There is a reason a child utilizes dissociative barriers, and it could be unsafe to dismantle these when the child has nothing to put in their place. What I found I can do, however, is draw on the knowledge I have about communicative development. I can provide the child with a model for healthy communication and a healthy child–adult relationship by listening and reflecting back what I see. I can help by wording physical states, naming emotions, and staying honest about my own feelings. I can assist the child in understanding the world better by clarifying cause–effect and the difference between consequence, responsibility, and blame. I can teach the child a vocabulary and give the child linguistic structures with which to tell stories so that the child can narrate his experience better, traumatic or not.

> Increased verbal skills are not only important for external narrative, but are also crucial for internal narrative—how we explain our reality to ourselves. A child who is better able to put events in context (internally, as well as externally) has better tools with which to prevent overwhelm and reduce the likelihood of needing to dissociate from the event (Herman, 1997; Osofsky, 2011; Pearce and Pezzot-Pearce, 1997; Perry and Szalavitz, 2006; Silberg 2013).

I can offer reparative communicative experiences and increase experiences in areas where there are comprehension and relational delays. Even if these skills do not directly address dissociation, they can help the child

learn to communicate better and thus feel less overwhelmed. As stress decreases, coping skills other than dissociation can be more easily learned, internalized, and used.

"In some ways," I say to Mr. Kay, "you, too, have unique opportunities to make Leroy's life easier. You might not be able to explore with him why he gets aggressive, but you can give him opportunities to release his body's energy in a positive way. You can also teach him how to wait his turn, how to follow directions and obey reasonable rules. This is also a way to help him."

> The more school personnel can be "on the child's side," the safer the school will feel to an overwhelmed child. Leroy used to hate gym—he would always get in trouble for grabbing or pushing or yelling. Last year, he was actually barred from gym because he disrupted the class for other children. Mr. Kay did not know what to make of the boy last year, but he is eager to understand Leroy better now and is very open to the notion that trauma reactions govern many of Leroy's responses. He is willing to try to do things differently and is generally viewing the child now through a lens of compassion, rather than exasperation. Awareness of a child's plight often results in increased compassion toward the child and, subsequently, in gentler interactions, improved communication and attachment, and, therefore, an increased sense of safety (Cole et al., 2005; Levine and Kline, 2007; Silberg, 1998, 2013; Wallin, 2007).

Following our meeting, Mr. Kay gives Leroy "jobs" to do: he asks Leroy to hold the ball until it is needed, requests Leroy help with the mats, and basically finds ways to keep Leroy at some distance from the other children while having him remain part of the class, feel helpful, and keep busy. When Leroy has "a bad day," Mr. Kay lets him go to one of the corners of the gym and "practice balance board" (a genius suggestion, I think, because it requires the boy's undivided attention and, as a result, helps him become grounded again fairly fast).

Leroy continues to make small gains.

In the week before Easter, I come to take him to speech when a child accidentally brushes against his arm. He jumps at her, screaming: "Don't hit me! Don't hit me! I kill you!" The girl returns a punch and the room explodes with screams and cries.

As the girl is being peeled off by a teacher, I attend to Leroy. He fights me, screeching: "She hit me, don't hit me, I kill her!" He ends up in my lap, head in the crook of my arm, looking angry, lost, and absolutely terrified.

"It's me, Ms. Y," I reiterate the grounding script I have used so many times before. "You are in the classroom, and I'm holding you, and you

are safe." He nods, registering recognition at the familiar words, face, tone, and voice, but still appearing confused. He looks around (maybe following the many times I had suggested he do so to see where he is and see he is safe). His heartbeat slows as we breathe together for a moment or two, allowing time for him to get his bearings.

I help Leroy up and walk with him to the classroom's sink, where I give him some water and he allows me to wash his face. A "what happened?" expression is written all over him.

Looking puzzled but not agitated, he listens as I tell him that the child touching his arm perhaps surprised and scared him. I am careful to present it not as a judgment, only facts.

"She hit me?" he keeps asking, "She hit me?"

It is common for Leroy to need repeated reiteration. I reiterate who had touched first, what he and the other child might have felt (surprise, fear, anger, pain), and what happened next. Even under the best circumstances, Leroy's understanding of sequence is still spotty, let alone under stress.

We end up having our session right where we are, sitting together by the sink, and it becomes an opportunity to teach about harm and apology, and about the sequence and vocabulary that go with them. I share how sometimes I might hurt someone's feelings and how it makes me feel sad and sorry inside, how apologizing makes me feel better, even if the hurt was unintentional.

Leroy listens raptly, captivated with validation and curiosity. Though he had been instructed to apologize numerous times, it is not likely that he was ever taught the process of apology—how it can be uncomfortable but how apology can help make things okay. His eyes widen when I ask him to let me know if I ever mistakenly hurt his feelings so that I could apologize to him. I am sure he had received scarce if any apologies, let alone been asked to say when one is needed.

> Children cannot do something they have never experienced before (Baron, 1992; Schiefelbusch, 1986). My offering apology to him might allow him an experience (as well as help form a neuronal and behavioral baseline) from which to then generate his own experiences of apologizing.

At the end of our session, he walks me to the classroom's entrance and, as I leave, pulls me to kneel next to him and rests his head on my shoulder.

"I . . . I . . . I sorry . . ." he mumbles.

"I know," I reply, returning a hug.

Finding Words

As the school year slowly winds down, Leroy still hits other kids. He still yells obscenities, still denies things he clearly did. However, he rarely

explodes during sessions, and when he does, grounding and comfort bring him back quickly. We wait to discuss what had happened until he is calmer. Stories of everyday feelings (things that made me happy, sad, angry, afraid) help him realize his own feelings. He listens even when not fully comprehending.

He learns to understand cause and effect. He can retell a story, can recognize and name anger, sadness, fear, pain, hunger, and fatigue, as well as happiness and pride. We role-play by talking for puppets and animals. We narrate scenarios of crayons grabbed, playground conflict, and daily events. He still pounds puppets, but he is also able to have more evolved symbolic play. He interacts better with C.K. and, at times, manages to use language (versus action) to seek help.

One day when C.K. grabs a marker from his hand, Leroy does not explode in blind rage, but calls for me: "Ms. Y, he take my marker, he make me mad."

When C.K. apologizes, Leroy accepts the apology with a gracious (and proud), "You welcome. You get it when I done," and, indeed, hands the marker over as soon as he finishes coloring the segment he was working on. Such interactions are small but profound progress for a child who could not as much as identify anger in the past, let alone pause to name it and have it processed in a verbal interaction.

Leroy's classroom behavior improves, too, even if not as dramatically as his behavior in sessions. His listening and his academic performance improve slightly, and he learns to enjoy the praise that the teachers creatively dole out. He still has horrible days, when he comes to school in combative (i.e., triggered) mood, and no amount of safeguarding can prevent him going into dissociative rage or meltdown tantrums. Such days are disproportionately frequent on Mondays (after the weekend) or following vacations. His teachers and I suspect that his "bad days" follow visitations with his mother or other family stresses.

Hoping to help bridge the sense of care he has at school to his home interactions, I offer Leroy a toy from my office "to take care of" during vacations. The first time I offer this, he becomes anxious, and I wonder if he is worried I would be angry if it got lost or broken. He still looks worried after I reassure him I will not be upset. It occurs to me he might get in trouble showing up with a toy from school and not be believed if he said he was allowed to take it home and get punished for "stealing." Indeed, when I add that I will put a note in his bag telling his grandma that I asked him to take care of the toy for the vacation, he smiles with relief and shyly chooses the cowboy. His smile grows wider still when I suggest he take the horse as well "so that the cowboy won't be lonely." He carries the toys in his pocket all that day and brings both back after the break without being asked, something I find quite touching. He chooses other toys at other times, always bringing the figurines back.

School days after holidays are still difficult. However, there are other days when Leroy does not have even one outburst. He interacts more with peers, and is kind, even gracious. There are times when he is accidently bumped into and does not punch back.

By the year's end, Leroy still hits and kicks, though less viciously and less frequently. When he does explode, he is more easily soothed and more open to explanations that include his culpability. He increasingly follows directions on required consequences.

It is no surprise that his progress is limited. Whatever is disturbing him is clearly still present. We are applying band-aids, but the core pain is still there. Leroy needs safety, and he needs trauma counseling. He needs a place to process and manage his dissociation and deal with his history. In the meanwhile, he is at least better able to verbalize, and can occasionally pause between the trigger and punching. He can request help. He feels safer, more connected, and better loved at school.

Though still quite aggressive, Leroy also begins displaying a caring, affectionate side. As with many of my more troubled students, his physical interactions in the past were almost exclusively limited to aggression and violence. Through modeling gentleness, I hope to help teach positive tactile interactions, as well. I told Leroy early on (as I do to other children I think could use more affection) that I love getting lots of hugs every day. Leroy is deliriously happy to fill the quota, running after me in the hall to wrap his arms around my hips and ask: "You need more hugs today, Ms. Y?" A few precious times, as he spots me entering his classroom, he throws his arms around me and says, "Hi . . . Ms. Y . . . I love you Ms. Y."

Leroy's speech and language show relative gains, but he improves in many ways that are harder to measure. Learning the vocabulary for emotions gives him a baseline of verbal skills with which to communicate his needs. Improved verbal skills also allow better internal verbalization of his reality, and possibly augment his ability to maintain a calmer internal state.

Having a calmer nervous system gives him the baseline with which to communicate verbally, reinforcing a positive feedback loop (instead of the previous overwhelm–confusion–dissociation–overwhelm loop). Though Leroy's academics remain delayed, his growth in attachment and trust is promising and deeply touching. His ability to stay present is a major achievement.

As the year comes to a close, I have to bid farewell to Leroy and the other students on my caseload in the school. I never know if I will be asked to return to the same school the following year. Most of my students have had more than their share of people moving in and out of their lives, and I am loath to leave them after the attachment they risked developing.

It breaks my heart to add in any way to their losses, disappointment, and pain.

As part of closure during the last sessions, I give each of my students a little journal—a keepsake—adding a handwritten dedication that I write in their presence, narrating aloud what I write. I want them to feel that I mean it and to remember that I truly cared, even when I am no longer there.

It is not clear to me how much Leroy understands about closure. Time and future are still hard for him to grasp. He is glad enough for his journal and is pleased with what I write in it about him being a caring, brave, smart boy I am so glad to have had a chance to work with. Repeatedly opening the journal as if to reassure himself that the dedication is still there, he asks me to reread it several times. I also decide to give him the firefighter that we used at his classroom (and leave another one with the teachers, to give his next year's staff).

"How about Firefighter coming to live with you now and being yours?" I offer, "Do you think you can keep him?"

"Yeah," he says seriously, "Ok." He gently puts the figure in his pocket. "I take care of him every day. He not going to fall down."

Afterword

By September, I am in another school and so do not see Leroy again. I worry about him. Is he okay? Is he getting help? Do the teachers he has now help him stay grounded? Can he hold on to a memory of kindness and comfort? Was the little I was able to give him enough to make a lasting difference? Does he remember—someplace, even if devoid of my name or face—that he matters, that I care?

What I tried to do to help Leroy is far from sufficient. One day, all teachers will be trained to detect possible trauma, all speech-language pathologists will be versed in the language of dissociation, and all school psychologists will know to refer children for expert evaluation and help. One day, schools will be a place for children to be truly safe and S.O.S. calls in the form of negative behavior from children such as Leroy will grant them aid, not "bad egg" titles. In the meanwhile, I guess we need to trust that even the little things we do matter, and that each interaction of respectful gentleness and healthy relational modeling makes a difference. We need to trust that being present with a child and giving the child words matter. And that the Leroys of today will grow up even a tad better off for our intervention, and know a sense of being valued and heard.

Editor's Comment

Na'ama Yehuda has written a chapter that is extremely important for therapists, school personnel, and the many other professionals who come

in contact with children who have experienced trauma. Yehuda highlights for us what unidentified traumatized children may look like and the type of support these children need from the adults in their world. Those of us working in this area are acutely aware of how little is known by professionals who are not working directly in the area of trauma, not only about the effect of trauma on children but also about what constitutes trauma for a child. Yehuda points out the danger of misdiagnosis due to the similarities between dissociative behavior and behaviors seen in attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and bipolar disorder. Similarly, there was a danger of Leroy's speech problems being labeled solely as delayed speech development, rather than also reflecting the impact trauma and dissociation can have on the ability to communicate. Yehuda identifies that Leroy's speech and language problems are inconsistent, and that his naming difficulties center around feelings and personal objects and do not occur in all categories to the same degree—all indicators of trauma/dissociation effects.

Yehuda tells two stories: (1) her direct work with Leroy establishing a sense of safety and acceptance, developing ways he can calm and reorient himself, and teaching him new language and thinking skills; (2) her work with the teachers—educating about trauma effects, modeling new ways of identifying and responding to triggers, and encouraging the teachers as they interact with Leroy in new and different ways. In contrast to the earlier chapters, here we see a child in his real world reacting to ongoing daily triggers and, in the effort to protect himself, responding in ways that antagonize both peers and adults.

Because Yehuda is not a mental health therapist, her work focuses on the first stage of the three-stage treatment model we have been discussing—safety and stabilization. Yehuda describes and demonstrates the importance of calming and reorienting. She highlights what we too often forget—that the child may *not* know what has happened. She clarifies that calming is not a single-experience learning but something that needs to be repeated many times and in as many different settings as possible (Perry, 2006; Perry and Dobson, 2013). As she models and teaches the words for feelings, body-states, sequence, and cause and effect, Leroy's language functioning increases. With this, there appears to be a slowing down of internal reactivity and a concomitant decrease in behavioral reactivity. This parallels in many ways what the other authors describe as their helping children move from drawing or play reenactment to talking about the trauma and, as a result, less uncontrollable reactivity.

While working diligently to provide new and more positive experiences for Leroy, Yehuda is keenly aware of the limits of her scope of practice. At several points in the chapter, she indicates material that would have been important for a psychotherapist to be told about, if, indeed, Leroy had been working with a psychotherapist. Teachers should take careful note of these points, because communication with therapists around

dissociative behavior that is observed at school can be very helpful for therapy, as noted by Waters and by Wieland.

Yehuda's moments of frustration are not with Leroy or with the teachers who are eager, if sometimes skeptical, to learn new ways to react to Leroy. Rather, the frustration is with the school psychologist who has little understanding of trauma and is dismissive of both Leroy and Yehuda. For Yehuda, this is one more day of working with the mental health bureaucracy; for Leroy, it is a lost opportunity for help.

Hopefully, not only every therapist working with a traumatized child reads this chapter, but also each therapist will pass the chapter to other professionals working with these children. Many of the children these professionals see may not be as extreme as Leroy, but teachers, day-care providers, occupational therapists, speech and language pathologists, and even parents can learn from this chapter new ways to respond to and help a traumatized and frightened child.

Although Yehuda does not provide psychotherapy for Leroy, within her work as a speech and language pathologist, she does provide many parts of the first stage of therapy—safety and stabilization. Basing much of her work on the neurological research related to the effects of trauma on children (see Chapter 1), she emphasizes calming, predictability, and teaching language that enables recognition and awareness of emotions (the opposite of dissociation) and helps place events in context. She provides numerous ideas for grounding (i.e., moving from a triggered neurological alarm system back to the reality of what is happening): eye contact; using the child's name, one's own name, where one is and what happened; naming the child's experience (attuning); providing an alternative activity; recalling an earlier positive connection; breathing; providing an object linked with calmness; sensitive touch; and use of a balance board (an idea from the gym teacher). Yehuda describes her own use of imaging and "energy work" (forms of mindfulness) to calm herself which, as Siegel (2010) explains, activates the medial pre-frontal lobe with its neuronal pathway to the amygdala, the anger/fear center of the brain that experiences a negative correlation (i.e., calming) to medial pre-frontal activity. Yehuda's patient work with the teachers, which is always respectful of the many demands on them, enables them to feel closer to Leroy—creating a more positive attachment (right hemisphere responding, Schore, 2013) which, in turn, calms their reactivity—"less scared/scary" (ibid: 53)—with Leroy. As they calm, Leroy calms.

The ability to put both feelings and events into words, and to verbalize cause and effect (primary work within speech and language therapy), moves these experiences from right hemisphere more emotional, somatic, immediate, and unconscious processing (Schore, 2012) to left hemisphere conscious processing (Schore, 2012), which enables the child: (1) to place his experiences in context—greater awareness of what happened then and what is happening now (Brewin, 2005); and (2) to express to others what

he is feeling and what he needs. As Yehuda links the psychodynamic term "internalizes" with the neurological term "forms neuronal pathway," she draws our attention to what the brain needs and, thereby, helps us to be more precise in our thinking and our work with children.

Yehuda, through varied communicative interactions, provides Leroy with language for the affect (in many cases, fright and hurt) he is avoiding (see Silberg's Affect Avoidance Theory, 2013). Improving language and communication enables the child to build linkages (Putnam, 1997), to communicate between parts (Watkins and Watkins, 1993), and to be less phobic of what had been split off into the emotional parts (EPs) of the personality (van der Hart et al., 2006). Much of Yehuda's work focuses on strengthening self-awareness through mind–body connections.

Yehuda stresses the importance of educating school personnel about the effects of trauma, what dissociation looks like, and how to help the child (Perry and Dobson, 2013). Here, Yehuda is utilizing aspects of Silberg's EDUCATE treatment model (2013): Educating teachers, noting where Dissociation may be occurring, helping Leroy Understand his feelings, Claiming emotions, regulating Arousal, recognizing and shifting Triggers. There is no Ending, in that further therapy is not available for Leroy and his grandmother. Yehuda's experience with Leroy highlights for us how supportive, and potentially curative, work can be done with traumatized children within the school setting.

As noted, with the teachers' increased understanding of Leroy's experience, they are better able to relate to and attach with Leroy. At the beginning of this case study, the attachment pattern between the teachers and Leroy would certainly fit a disorganized pattern (see Liotti, 2009) that was reinforced by behaviors on both sides. Toward the end of the case study, one sees considerable calming within the Leroy–teacher relationship and a movement toward at least some times of secure attachment (certainly between Yehuda and Leroy). Thus, in this chapter, we see how information from both the neurological and the conceptual models of dissociation assists in the understanding of and work with children who dissociate.

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8 Conclusion

Fragmentation to Integration

Sandra Wieland

The children and adolescents you met in the previous chapters are now moving ahead in their lives with greater internal stability. This does not mean that everything is as we would wish it to be—Dalma is back with her birth mother, who still does not acknowledge the abuse and has little ability to protect her daughter, and Leroy continues to live in what appears to be a chaotic world, with losses and confusion that have not been processed. Yet these children (as well as Jason, Ryan, Joey, and Angela) have had the experience of having their internal world seen and validated, and have learned ways to calm their systems and to acknowledge frightening feelings, sensations, and events.

There is the strong possibility, if trauma recurs, these children will again use dissociative mechanisms to protect themselves. But along with the dissociative coping, they will have a stronger core self. They may even be able to remember the therapeutic and supportive work that made a difference for them in the past. This stronger core self, together with an improved ability to listen internally and to put words to their experiences, may enable these children to modulate the emotional, physiological, and experiential impact of future trauma.

In the introductory chapter, dissociation was described, and both neurological and conceptual models of dissociation were reviewed. Particular attention was given to how these models can assist therapists in their work with children and adolescents. Considerable overlap was found to exist between the therapeutic directives derived from the different models—the importance of attention to the attachment relationship; the need not only for safety, but also for a sense of safety and the ability to self-calm; as well as psycho-education about trauma and dissociation. Overlap between models also exists with regard to the importance of awareness of dissociated feelings, sensations, memories, and, for some children, the dissociated self-states; increased internal communication between self-states; the ability to differentiate between the past and the now; trauma processing; and integration. These themes can be found in the clinical cases presented.

Establishing and Strengthening Attachment

Reading Baita's description of Dalma's therapy, we learn about efforts to engage a mother in the child's therapy that were unsuccessful. As noted by Schore (2012), if a mother has not had any assistance with her own experiences of disorganized attachment and trauma, she will be unable to attune to her child's experience. The subsequent negative effect on the child's therapy was discussed.

Parents play an important ongoing role within Jason's (Marks), Ryan's (Waters), and Joey's (Wieland) therapies. Within Angela's therapy (Silberg), the mother is invited in at specific times and provides an important part in resolving the trauma distress. For Leroy (Yehuda), the parent figure is not involved. Because the interactions with Leroy take place within the school setting and grandmother chooses not to be involved when invited, work related to the primary attachment figure does not occur. An attachment relationship that might be described as a peripheral but yet 'pivotal attachment' is built between Yehuda and Leroy, and clearly plays a major role for Leroy. "Peripheral but pivotal" can be used to describe the attachment relationships between the other therapists and the children with whom they are working. While the attachment with the therapist is pivotal, the primary relationship is between the parent-figure (birth, foster, adoptive). Strengthening the primary attachment needs always to be the therapeutic focus.

Safety and Calming

Dalma experiences safety within her foster home and within the therapy setting, and symptoms of dissociation decrease. Baita's patience, as well as her close attunement to and movement with Dalma during the individual sessions, would have provided and modeled calming for Dalma. The reappearance of dissociation in Dalma's behavior during family sessions with her mother highlights the link between lack of safety and dissociative functioning.

Despite previous attachment therapy, Jason had not (due to dissociation) been able to internalize the safety his adoptive mother was providing. Recognizing and working with the separated states that blocked this awareness of safety was a crucial part of Jason's therapy. In his case, calming was provided through early developmental soothing activities (being rocked, drinking from a bottle, being fed caramels).

Waters describes the importance of continually checking in with the child with regard to safety. Because Ryan's first two years of life were years in a calm and secure environment, teaching calming was not a major part of his therapy.

For Joey, safety in the present existed but, as with Jason, Joey had not been able to internalize this safety. Eye Movement Desensitization and

Reprocessing (EMDR) helped Joey internalize, first, his home and, then, his family as a place of safety and provided calming. Wieland helped the parents to recognize where their responses threatened Joey's sense of safety and helped them develop more stability in the home.

As with Ryan, Angela's early years provided a base of safety and an internal ability to calm. Although this secure base was disrupted by the assault and later illnesses with intense physical pain, Angela's early experiences meant that issues around safety and calming did not need to be a major part of her therapy.

Yehuda's work with Leroy provides the clearest examples of ways to provide a sense of safety and to build skills for calming. It is particularly important to note that Leroy was able to experience, and subsequently learn, self-calming without therapy intervention. The ideas presented by Yehuda are particularly helpful for parents, teachers, and other professionals working with children with dissociation.

Psycho-education

Psycho-education about dissociation is important for the child, parents, or other caregivers, other professionals, and also the therapist. Because Baita describes a case that occurred at the beginning of her work with dissociation, much of the educating she did was of herself. Within the therapy, she helped the child understand what was happening internally. Baita used the pictures of "her sisters" already drawn by the 4-year-old Dalma to help explain the dissociative process. Marks and Silberg used drawings of the brain to explain to Jason and Angela how trauma can become "walled off" within the brain. Marks redid the brain drawings several times during the therapy as different parts who may not have been cognizant of the earlier therapeutic conversations became apparent. Waters worked previously with Ryan's family and would have included education about dissociation at that time. In her case description, she emphasizes the important role a therapist can play in educating other professionals. Wieland drew diagrams to explain dissociation to Joey and his parents. Several of these diagrams were based on the Watkins's pie-shaped model. Silberg, in her work with Angela, described dissociation as a positive mechanism that helped Angela to cope with the trauma she experienced. Yehuda took on the very important role of educating the teachers.

The ongoing contact between Waters and Ryan's parents was an important aspect of Ryan's therapy and helped Waters continually assess what Ryan needed. Marks, Waters, and Silberg included the parents in the process of thanking each part for how the part had helped the child survive the frightening trauma. Waters, Wieland, and Silberg emphasized the importance of the parent holding the child responsible and accountable for all the child does, while not shaming or calling the child names. Wieland described the important work that often needs to be done with

the parent or substitute caregiver to establish a more consistent behavioral system at home.

Identifying Dissociated Self-States/Parts

These cases differ somewhat in how the therapists and, then, the children became aware of the dissociative states or parts. Baita (Dalma) became aware of the different states as the dissociated states presented in the therapy sessions with different voice tone, body posture, behavior change, knowledge, and amnesia for either the trauma or present events. Some parts or self-states of 4-year-old Dalma even introduced themselves. Drawings were also used to help identify some parts. With Jason, Ryan, and Angela, the therapists asked the child to look around inside or listen inside for the part of them that may know more about some situation. Concerns related to possible hidden parts and how this issue can be approached are described by both Waters and Silberg. Wieland asked Joey for drawings of the part of self that did something and the part that wished it had not done it. With Leroy, these types of interventions did not occur, as Yehuda was very careful not to venture beyond her scope of practice (language and development) and not to open up issues related to trauma processing.

Fostering Internal Communication

Although neither Baita nor Waters encouraged specific parts to present themselves in the therapy session (as opposed to talking through the core or presenting self), this did occur. In each case, the therapist responded with respectful acknowledgement and interest. Waters, as a way to encourage communication and integration, suggested to Ryan's parts that they work together with Ryan. Talking with the dissociated parts through the "child in the room" was emphasized by all the therapists. Increased internal communication can be seen as each clinical case progresses. Drawings and play enactment were an important part of increasing internal communication within Dalma. Baita's careful explanation to Dalma as to why these "sisters" had appeared clearly increased the sense of continuity inside. Both Marks and Waters used clay and drawings to represent different self-states and then symbolically placed them together. Waters used metaphors (e.g., hockey) for describing teamwork among parts.

In the clinical cases handled by Marks, Waters, and Silberg, considerable work is done to help the child/adolescent "talk inside their head" to the various aspects of themselves. They are asked to "check inside" as to what other parts of them have to say or feel, to thank internal parts for how they have helped them survive, and to assign new jobs and (for Jason and Ryan) new names to these parts. Although similar "inside talking" is encouraged by Wieland for Joey, because Joey has less-defined parts (does

not have dissociative identity disorder (DID)), this communication does not involve new jobs or names. Respect for the child, as well as each aspect of the child, is evident in all of the clinical cases.

Processing Trauma

Trauma processing was an important part of each therapy described. With Dalma, as the dissociative part holding a particular part of the trauma presented in the session, Dalma often reenacted the trauma through either play or body response. This reenacting and then discussion of what happened provided trauma processing. Marks, working with a 7-year-old boy, used active physical activities together with EMDR tapping for processing and releasing the trauma held inside. She stresses the importance of taking the child back to the trauma—no matter how far it has been cut off—and providing ways to release the anger, grief, and shame internalized from that time. Waters encouraged Ryan to use clay to represent what had happened to him, or what he felt. Wieland helped Joey and his parents talk more openly about his mother's death and the frightening presence of his father. Specific periods of trauma (highlighted by a timeline) were processed using drawings and EMDR. For Angela, a significant part of the processing of the medical trauma was her expression of the anger and resentment toward her mother. As for the assault she experienced, retrieving and then talking about the memory provided significant trauma processing.

Moving from situationally accessible memory to verbally accessible memory (Brewin, 2005), and from unconscious memory to conscious memory (Schore, 2012) was apparent in each of the therapeutic cases. The therapists attended not only to the memory of what had happened, but also to the sensations and emotions experienced. This can, within the structural dissociation model (van der Hart et al., 2006), be viewed as the apparently normal part of the personality (ANP) recognizing and acknowledging the emotional parts of the personality (EPs) that had been split off. As the children were encouraged to own and express frightening emotions, the dissociative behaviors/identities developed to avoid affect (Silberg, 2013) were no longer needed.

Applicability to Other Cases of Trauma and Dissociation

Although the clinical cases presented focused on children and adolescents with more extreme dissociation (dissociative identity disorder, or dissociative disorder not elsewhere classified), it is essential for therapists to be alert to symptoms of mild and moderate dissociation. While children who use dissociation as a way to cope with a frightening world (or frightening events within an otherwise stable world) do find a successful way to handle fright, they lose the opportunity to learn healthy ways of

coping. As future negative events occur, these children will respond with what has been successful in the past, and more dissociation occurs. As therapists working with children and adolescents, it is important to be alert to all levels of dissociation and address this dissociation, however mild, as we work.

The three-stage trauma therapy model (Briere, 1992; Herman, 1992), referred to in Chapter 1, was utilized in each of the cases presented and can be helpful in all cases of trauma and dissociation. This trauma processing model fits well with Silberg's EDUCATE model. During the first stage of safety and stabilization, attention was given to attachment (Silberg's "A"), safety, calming (Silberg's "A"), and psycho-education about the effects of trauma and the role of dissociative mechanisms (Silberg's "E" and "D"). During this first stage, therapists need to be alert to the many aspects of trauma response that may have been dissociated (e.g., body sensations, anger, grief, fear, loneliness, memories) (Silberg's "U") and to help the child reconnect to these sensations, emotions, and knowledge (Silberg's "C"). First-stage interventions need to be continued, as they were in the clinical cases, as therapy moves into the second stage of trauma processing (Silberg's "T"). For children with mild or moderate dissociation (similar to Joey and Angela), the last stage of therapy does not focus on integration but, rather, assists the child in developing new coping skills and moving on with life (Silberg's "E"). For children with more severe dissociation *and* who are living in a safe setting (similar to Jason and Ryan), activities encouraging integration (Waters' use of a soccer team metaphor) can be used. For children such as Dalma who are living in an unsafe setting, internal communication is encouraged but specific integration activities would not be suggested.

It is suggested that therapists not only read this book to further their understanding of dissociation and to learn new skills for assisting children with dissociation, but also to use it as a resource while working with specific cases. Each clinical case presents a unique child with a unique history and, therefore, a unique dissociative system. And yet, all child and adolescent therapists will see some version or, more likely, some combination of Dalma, Jason, Ryan, Joey, Angela, and Leroy in their practice. As therapists work with these children and adolescents and struggle with how to help them, rereading these clinical cases will provide both ideas and reassurance—ideas to use within the session and reassurance that therapy can make a difference. Working with traumatized and dissociative children is a developing field. As each therapist draws in the experience and knowledge of others, and uses this together with their own experience and knowledge, children and adolescents who have suffered trauma will be able to move on to a healthier, integrated life.

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