Guidelines for the assessment and treatment of children and adolescents with dissociative symptoms and dissociative disorders.

Child and Adolescent Committee of the European Society on Trauma and Dissociation (ESTD)

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1. Introduction

As ESTD Child and Adolescent Committee we became aware in our discussions about the guidelines, that there are many commonalities but also differences in our work with dissociative children[1]. These guidelines try to build a common basis based on research, guidelines (see reference list), information from conferences, advanced trainings and the clinical experiences of the ESTD Committee. We especially acknowledge the Taskforce (with specific reference to Joy Silberg and Frances Waters), which developed the ISSTD guidelines for children and adolescents for their pioneering work, research, training and guidance. These guidelines for children and adolescents differ from the guidelines for adults in a few distinctive aspects, but there are also similarities. Although dissociation in children and adolescents are still often under-recognised, it has become a rapidly developing field. Treatment strategies aim to reduce symptoms through increased emotional regulation, effective trauma processing, reduced dissociation and promote integration. The most successful treatment approach to an individual case often is the most eclectic, with the clinician showing flexibility and creativity in the utilization of a wide variety of available techniques (ISSTD, 2003). However, these guidelines can guide clinicians in structuring and planning the assessment and treatment of children based on the highest level of evidence of it effectiveness.

Since treatment differs for specific age groups, the treatment paragraphs are divided into the age groups 4-18 years old and 0-4 years old. These guidelines indicate the degree of evidence of each recommendation by:

- Minimal Standard (MS) with evidence from RCT's and other research. Because of the lack of research in this field there are no recommendations that fit the MS criteria.
- Clinical Guidelines (CG), which is based on expert's opinion, expert's consensus and case studies.

[1]The word child can be replaced by adolescent throughout these guidelines.

- Options (OP), which is based on ESTD expert's opinion, case studies, but no expert's consensus.
- Not Endorsed (NE), which is discouraged.

2. Goals

Goals for the treatment of children and adolescents with dissociative symptoms are:

- To establish safety for the child to the fullest extent possible, to recognize and prevent trauma and reenactments (Ford & Courtois, 2013; Silberg, 2013)
- To promote stabilization and emotional regulation (Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Evans, Andres, Cohen, Blaustein, 2011; Silberg, 2013; Struik, 2014).
- To provide ways for the child to process traumatic experiences (Silberg, 2013; Struik, 2014; Waters, 2016;Wieland, 2015).
- To establish integration of the dissociative states and enable the child to develop an integrated sense of self. (Silberg, 2013; Struik, 2014; Waters, 2016; Wieland, 2015).
- To re-integrate the child back in age appropriate levels of functioning across all domains: cognitive, emotional, social and relational. In this way children can develop a sense of agency, competency and mastery over their minds, bodies and lives again (Arvidson et al, 2011; Silberg, 2013; Struik, 2014).

3. Qualifications

Since working with these children can be challenging, the following qualifications are recommended:

- Clinicians should be registered or accredited by the appropriate professional societies in their country of practice.
- Clinicians need sufficient knowledge of child development and child mental disorders.
- It is recommended that clinicians attend training, workshops and conferences from clinicians recognized in the field as knowledgeable and experienced in working with children with complex trauma and dissociation and teaching from a recognized theoretic framework.
- Since this is a developing field, clinicians need to have up to date knowledge of different theories on complex trauma and dissociation in children and adolescents.
- It is recommended that clinicians align themselves with national or international societies on the studies of trauma and dissociation (ESTD and/or ISSTD) in order to access research and update their information on dissociation in children and adolescents.
- Clinicians need self-reflection and internal stability. They need to be able to set and maintain boundaries and reflect on themselves on the multiple transference phenomena as well as within their organization.
- Because of the strong positive and negative (counter-) transference when working with these children and parents, clinicians should have access to regular (peer) supervision or consultation to reflect on these phenomena and prevent vicarious traumatization.

4. Theoretical basis

Dissociative symptoms in children were found to be associated with the following experiences:

- Traumatic experiences (Anda, Felitti, Bremner, Walker, Whitfield, Perry, 2013 Coons, 1996; Dell & Eisenhower, 1990; Hornstein & Putnam, 1992; Nilsson 2007);
- Neglect (Brunner, Parzer, Schuld, & Resch, 2000; Ogawa et al., 1997);
- Rejecting and inconsistent behavior in parents/carers (Liotti, 2006, 2009; Mann & Sanders, 1994);
- Traumatic physical experiences and medical treatment (Stolbach, 2005).
- Perpetrator Introjects (Potgieter-Marks, 2012, Waters, 2016, Potgieter-Marks, 2016 (to be published in October in Germany)

Both the ICD-10 and DSM-V still have their limitations regarding the diagnostic aspects of complex trauma and dissociative disorders for children and adolescents.

As a theoretical basis it is important to have a good knowledge and understanding of the neurobiology of trauma and dissociation and the impact trauma has on the developing brain of the child (Ford, 2009; Perry, 2013; Schore, 2009; Silberg & Dallam, 2009; Silberg 2013; Stien & Kendal, 2004; Wieland, 2015). Because of the severe impact of trauma on the development of the brain, especially in early childhood, the child shows physiological, emotional, relational and cognitive disturbances (dysfunction) as well as behavioral (Perry, 2009; Ludy-Dobson & Perry, 2010).
The clinician also has to have a good understanding of the impact of trauma on behavior and the presentation of dissociation in children (Andrea, Ford, Stolbach, Spinazzola, & Van der Kolk, 2012; Stien & Kendal, 2004). Since attachment plays a critical role in the treatment of children, clinicians also needs an understanding of the child's attachment experiences and how traumatic experiences might impact the attachment of the child. Disorganized attachment patterns occur disproportionately often in the abused cases with a preponderance of disorganized/disoriented attachments in the maltreatment group (82%) (Carlson, Cicchetti, Barnett & Braunwald, 1989). Bowlby's Attachment Theory and the Disorganized Attachment Model (Liotti, 1999; 2006; 2009), explaining the emergence of different internal models of self and others that creating a vulnerability to dissociation, are important theories for assessment as well as treatment. Barach (1991) linked fragmentation of the self in borderline personality disorder to attachment. Research conducted to study the level of dissociation in relation to childhood trauma (sexual/physical abuse, witnessing inter-parental violence), early separation from a parent, and perceived parental dysfunction show that dissociation, although trauma-related, is neglect-related as well (Draijer & Langeland, 1999).
Van Dijke et al. (2010, 2011, 2015) linked dissociation also to dysfunctional patterns of self- and affect regulation in adults and dissociation associated dysfunctional patterns of regulation is found in several imaging studies (Lanius, et al, 2010). Van der Kolk (2005), Perry (2006), Silberg (2013) and Struik (2014) link abuse, neglect and trauma to emotional regulation problems in children.

Clinicians need to understand and use at least one theoretical model on dissociation[2]. The most familiar theoretical models for adults at this stage are: The Ego State Model (Watkins, 1978; Watkins & Watkins, 1993,1997), the Behavioral State Model (Putnam, 1997) and the Structural Dissociation Model (Van der Hart, Nijenhuis & Steele, 2006). This model describes that when children at a young age are forced to survive through dissociation for a prolonged period, their integrative functions can become compromised to such an extent that, according to Van der Hart et al. (2006) structural dissociation of the personality occurs. The model of Structural Dissociation is widely accepted within the ISSTD and ESTD for adults and it has some research support (Nijenhuis, 2012; Reinders et al, 2003; Reinders, A. et al, 2006; Reinders, Willemsen & Vos, et al., 2012; Schlumpf, Nijenhuis, Chalavi, et al., 2013). When used in daily practice the Model of Structural Dissociation is very similar to The Ego State model. Struik (2014) describes the use of the Model of Structural Dissociation with children and adolescents, and Wieland (2015) and Gerge et al. (2013) describe the use of the Ego State model as well as the Model of Structural Dissociation with children. Silberg (2013) describes the Affect Avoidance Theory which relies on developmental literature, specifically Putnam's (1997) Discrete Behavioral States Model, attachment theory, affect theory and interpersonal neurobiology to explain how and why traumatized children develop dissociative coping strategies. *"The Affect Avoidance Theory provides an organizing theoretical framework for a variety of dissociative phenomenon. This framework views dissociative phenomenon from a normalizing and adaptive perspective. This model is attentive to the ways in which the child's deviations in consciousness, identity development, affect or behavior have served to protect the child, and this model provides a framework for redirecting the child incrementally back to behaviors seen in a more normative developmental trajectory*" (Silberg, 2013, p.17). Addressing a core problem in the dissociative child, namely avoiding of affect, is the essence of this theoretical model.
Waters (in Wieland (eds.), 2015) describes the Quadri Therapeutic Model for Treatment of Dissociative Children, which combines the principles from Dissociation Theory, Attachment, Developmental and Family System Theory. This model has now been adapted into the STAR theoretical model (STM). The STAR model describes all the theories, which need to be taken into account during treatment of the dissociative child. This includes the attachment, family system, developmental, neurobiological and dissociation theories. Waters (2016) emphasis the integration of all these theories while treating the dissociative child. All five theories "*are pathways that lead to or influence the use of dissociation in children and adolescents*" (Waters, 2016.p 4.) The essence of this model is to retain an integrative perspective when working with the complexities of the dissociative child.

5. Assessment

Identifying or diagnosing dissociation requires a thorough assessment targeting all areas of the child's development including exploration of dissociative symptoms. Specific symptoms likely to be of a dissociative nature are summarized below. (CG)

- The child might have 'imaginary friends/persons', 'inside friends that nobody knows about' or talk about an 'invisible friend'. These 'friends' or 'people' are

[2] Wieland (2015) and Dell and Mc Neil (2009) give an overview of different models.

usually outside the range or different in quality or function from normal imaginary friends of young children. These dissociative states may either be identified as helpers, protectors, carers, perpetrators or younger regressed self states. They usually do not resemble the imaginary friends young children have as playmates. The child might experience these dissociative states as helpful, controlling, conflicting or be afraid of these dissociative states or like 'to get rid of them' or hear them 'fighting' or giving the child 'messages'.

- The child may hear 'voices' in the child's head, talking, shouting or screaming. The child may experience voices telling the child to hurt, abuse, attack others or display inappropriate behavior.
- There might be a history of self-harming, sexualized or aggressive and violent behaviour.
- There might be a history of multiple unexplainable physical symptoms that have no somatic source. There can be somatoform dissociation with absence of awareness of body sensations or body experiences leading to for example enuresis and encopresis.
- The child can have amnesia around neutral, positive or negative events or behavioral incidents and denies any involvement in these incidents. The child may even report amnesia about things that happened minutes ago. The dissociative child is often blamed for lying, especially telling a lie despite the account of eyewitnesses. These lies are often viewed as 'unnecessary' or 'senseless'.
- The child's behavior may rapidly change from calm to aggressive, anxious, regressed or controlling. The child may also disclose bizarre information or show repetitive senseless/bizarre movements with the body. Children also often display a significant change in their voice and facial expressions during these changes.
- Inconsistent (fluctuating) performance is often reported. For instance the child might be able to do an activity well or display a skill one day and unable to do the same activity or use the same skill the next day. The child might also display similar inconsistencies in terms of preference for food or clothes.
- The child may struggle to connect to reality while doing tasks at home or at school and prefer to move into fantasy and/or alternate being different fantasy characters. The dissociative child struggles to connect to reality or is only able to connect to reality for limited periods of time to the point where the fantasy is having a negative impact on the child's general performance. This behavior usually differs from normal fantasy where the child enjoys fantasy, but is able to quickly move to reality and take up appropriate responsibility.
- School can report concentration problems, trance like states and learning difficulties often regarding tasks that require integrative skills (comprehensive reading or mathematics) or fluctuating skills in school activities. The IQ profile scores might be scattered or fluctuate when repeated over time. The child might display different types of handwriting.

During the assessment information provided by the child needs to be carefully explored without using suggestions and leading questions (Walker, 1999). Clinicians must be cautious of the child feeling pressurized to answer which might lead to the child starting to dissociate because there is a conflict between the dissociative states. When children are not safe and are still being abused or mistreated, they might be afraid to answer or disclose information about trauma or dissociative states and they might become very stressed from questioning or the assessment. The use of grounding techniques can ease the child's stress.

Children with dissociation or dissociative disorders often have symptoms or other disorders like Obsessive-Compulsive Disorder (OCD), eating disorders, PTSD, reactive attachment disorder (RAD), Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), affective disorders especially depression and bipolar II, substance abuse disorders, self-harm and suicide attempts, psychotic and/or pre-psychotic states, Autistic Spectrum Disorder, Conduct Disorders and Oppositional Defiant Disorder that can be either comorbid or misdiagnosed.

In making differential diagnoses one needs to make sure there is no general medical disorders, that may mimic dissociation, like seizure disorders, effects of drugs and neurological disorders, which need to be excluded.

The assessment should be comprehensive including the following (OP):

5.1 Clinical interviews (CG)

Information on the child's history, traumatic experiences, symptoms, current and past functioning and previous treatment, needs to be gathered from the parents, carers, child and teacher or school. The following components are necessary:

- Comprehensive information needs to be obtained regarding the history of the child with specific reference to early bonding, attachment relationships, traumatic experiences, emotional, social, physical and cognitive development, behavior and previous treatment (Waters, 2016).
- A full history of the child, with specific reference to traumatic experiences needs to be obtained during the assessment. A child's exposure to neglect, physical, emotional or sexual abuse, domestic violence, exposure to abuse by organized groups, community violence, bullying, (international) adoption, isolation, rejection, early separation, loss, death, severe illness or traumatic medical procedures needs to be explored.
- An assessment of dissociative symptoms described above and trauma related symptoms such as nightmares, flashbacks and high levels of anger or anxiety relating to certain stimuli (Waters, 2016).
- An assessment of the child's current situation, actual safety, present sense of safety, significant attachment figures, attachment relationships to parents or primary carers and other interpersonal relationships is required (Waters, 2016). This might lead to legal considerations.
- The clinician might have to repeat the assessment over time since children might initially try to hide dissociative symptoms (Struik, 2014).
- A thorough analysis of the child's file can produce information about multiple diagnoses, failed previous treatment, ongoing treatment with no effect and a general history of increasing or fluctuating emotional and behavioral problems.
- The presence of mental health problems, possible differential diagnoses, trauma-related symptoms or dissociation in the parents needs to be explored. Waters (2016) provides comprehensive information on how dissociation could be overlapping or misdiagnosed with differential diagnoses. This needs to be fully explored during the assessment phase.
- Yehuda (2016, p.171) advocates for a 'trauma-sensitive assessment", whether that is a psychological assessment or a speech and language assessment, as both can provide significant information relating trauma and dissociation.

- School can provide information about the child's functioning and behavior at school. These behaviors might also indicate significant information regarding trauma and dissociation (Yehuda, 2016)

Structured clinical interviews (OP)

- The DTD-SI version 8.0 (Ford and Developmental Disorder Work Group, 2011) is a semi-structured interview assessing trauma exposure, dysregulation, posttraumatic spectrum symptoms, duration and impairment based on the description of the Developmental Trauma Disorder (Van der Kolk, 2005).
- The SCID-D (Steinberg, 1993) is used for children from the age of 11. By design the SCID-D questions are meant for those age 11 and older (ie, 6th grade level). This has been tested in a number of (case) studies (Carrion & Steiner, 2000; Sar, 2014). To date, no systematic research studies have yet been conducted on populations younger than 11. The congruence between the ADES and SCID-D seems to be weak (Carrion & Steiner, 2000; Sar, 2014). Publications on the use of the SCID-D for younger children (11-17) can be downloaded at: http://ge.tt/9Cc2vEh1?c

5.2 Screening questionnaires (CG)

It is recommended to use at least one questionnaire to assess the child's posttraumatic stress and dissociative symptoms, specifically self-report checklists (discussed below) (Silberg, 2013; Waters, 2016). The interpretation needs to be done with caution. These questionnaires can confirm a child's dissociation, but *it cannot always exclude that a child is not dissociating* because these children often do not disclose their dissociative symptoms. The questionnaires can also be used as a basis for further interviewing about dissociative symptoms (Silberg, 2013). One needs to take into account that scores can increase instead of decrease after a period of treatment, because the child feels safer to reveal internal experiences more accurately.

The following questionnaires on dissociative symptoms are recommended:

- Child Dissociative Checklist (CDC) (Putnam, Helmers, &Trickett, 1993). A questionnaire for children from 4-14 years old, filled in by the carer with good validity and reliability (Putnam & Peterson, 1994). Teachers can also complete the CDC to determine the level of dissociative symptoms observed in the classroom.
- The Child Dissociative Experience Scale and Post Trauma Inventory (CDES.PTSI) (Stolbach, 1997, adapted from Bernstein & Putnam, 1986) can also be used. The CDES assesses PTSD and dissociative symptoms and is a self-report questionnaire for children 7-12 years old, but can be used for children12-18 years old as well. The CDES has been translated in several European languages (see http://www.estd.org).
- The Adolescent Experience Scale (A-DES) (Armstrong, Putnam, Carlson, Libero, & Smith, 1997; Farrington, Waller, Smerden, &Faupel, 2001; Smith & Carlson, 1996). The A-DES is a self-report questionnaire for adolescents to assess dissociative symptoms and experiences.
- The Somatoform Dissociation Questionnaire (SDQ-20). The SDQ-20 is a self-report questionnaire for adolescents from the age of 16 to evaluate the severity of somatoform dissociation.

Besides questionnaires on dissociative symptoms, standardized screening instruments can be used to screen PTSD symptoms, such as the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), The Trauma Symptom Checklist for Young Children (TSCYC (Briere et al., 2001), ASC-Kids (Kassam-Adams 2006), the Children's PTSD Inventory (Saigh, Yasik, Oberfield, Green, Halmandaris, Rubenstein, Nester, Resko, Hetz, & McHugh, 2000). The Child Behaviour Checklist (CBCL) for children 1-5 and 6–18, the Teachers Report Form (TRF) for children 6–18 and the Youth Self Report for children (YSR) 12-18 can provide valuable information on whether the child is in the normal, borderline or clinical range for posttraumatic stress problems (Achenbach & Roscorla. 2007).

5.3 Psychological testing (projective techniques, neuropsychological testing, etc.) (CG)

Formal and conventional psychological assessments cannot be used to diagnose dissociation, but the responses and behaviors exhibited during completion of psychological testing can support a finding of dissociation (Silberg, 1998). During the assessment the prevalence of dissociative symptoms can be observed, for instance, staring, chancing of voice, fluttering, blinking or rolling of eyes and/or the presence of imaginary play mates (Waters, 2016). The clinical assessment of the child itself should be complemented with:

- Age-appropriate projective techniques for instance drawings, the use of sand tray or toys (Silberg, 2013; Waters, 2016; Wieland, 2015). The child's drawings and general information during the assessment may reflect a significant absence of the normal expected integration of the self. The child might externalize the sense of self-fragmentation by using multiple dissociative states in body drawings, identify him/herself as multiple people or use multiple names for the self or not draw dissociative states as unidentifiable figures.
- The Inside-Outside Technique (Baita, 2015a) and (Baita, 2015b) where the child draws the outside of the head and the inside of the head was developed specifically for dissociative children during assessment and treatment. (CG).
- Specific questions should be asked relating to the dissociation for instance whether parents/carers are seeing rapid changes in the child, hear the child talk with different voices etc. (Waters, 2016)

Data from adult DID population (Personality differences on the Rorschach of dissociative identity disorder, borderline personality disorder, and psychotic inpatients show specific characteristics in the Rorschach test which might be taken in consideration for the adolescent population in further studies (Brand, Armstrong, Loewenstein, & McNary, 2009). Silberg (2013) also describes specific characteristics -higher number of morbid images and destruction- in responses to projective tests (TAT and Rorschach).

6. Treatment

Despite the lack of research data, the three-phased model developed for the treatment of adults (Herman, 1992) is commonly used for the treatment of dissociative children (ISSTD Guidelines, 2003). In the first phase, stabilization, the child needs to get stabilized enough to be able to face his traumatic memories and start trauma processing. The child needs to be able to cope with the stress that is associated with

these traumatic memories and use his abilities to think and evaluate. Stabilization seems to be imperative for dissociative children in order to do successful trauma processing.
Interventions in the stabilization phase need to be structured in a specific order, following the development of the brain. The neuro-sequential model of therapeutics (NMT) (Perry, 2006; Perry & Dobson, 2013) offers a model to evaluate trauma cases (by a functional brain map) and make recommendations for clinical work based on this neurodevelopmental approach. NMT highlights the importance of pattern repetitive activities for addressing poorly organized parts of the brain. Treatment is done with the child, parents and the network around the child and is systemically oriented (Arvidson et al, 2011; Struik, 2014; Waters, 2016; Wieland, 2015.).
Contrary to the work with adults, it is not necessary to know the complete internal world of the child from the start. Work with parts of the personality is only done to reframe negative dissociated content (Silberg, 2013; Struik, 2014; Wieland, 2015; Waters, 2016).
In the next phase, namely trauma processing, the traumatic memories are processed. In the last phase, the integration of dissociative states and moving on to age appropriate behaviour, the child is working on better coping strategies to deal with stress, in order to prevent future trauma and to continue life in a more functional way.
During the stabilization phase as well as during the trauma-processing phase, the clinician has to pay attention to the functioning of the dissociative states. They may surface in play, symptoms or behavior. The child needs to get to know and understand these dissociative states: their feelings, their wishes, their function, what they stand for, what they need. They can be identified in the stabilization phase as well as later on during trauma processing as younger frightened or needy dissociative states, as helpers, protectors, carers or perpetrator introjects..This represents the phase of understand what is hidden (U in the EDUCATE model) as well as claiming what is hidden as one's own (C in the EDUCATE model). It is important for the clinician not to encourage the dissociative states to come out or to communicate directly with them. The task of the clinician is to remain congruent and respectful towards all dissociative states and rather encourage the child to 'Listen In' (Silberg, 2013) or 'Check inside' his head or mind (Waters 2016) when the clinician needs information regarding the dissociative state. This enables the child to connect to the dissociative state and promote internal communication and control over the more complex dissociative states. This also enables the child to claim what is hidden (C in the EDUCATE model) (Silberg, 2013). It promotes accepting the feelings, sensations, fear and anxiety about the hidden parts of the self and makes sense of its origins. This process also enables the child to develop age appropriate autobiographical memory as the child can work with the therapist to connect the origin of the dissociative state to an actual traumatic event in the life story/history of the child. Waters & Raven (2016) suggest the use of art in collaboration with psychotherapy, especially in the case of hidden states. The only time that the therapist will engage directly with a dissociative state, is when the dissociative state presents in the room and the child cannot be accessed in any other way.
Silberg (2013) describes five treatment principles namely:

- An attitude of deep respect for the wisdom of individual coping strategies;
- An intense belief in the possibility to heal and the potential for future thriving;
- Utilize a practical approach to symptom management;
- Create a relationship of both validation and expectation;
- Recognize traumatic symptoms as both automatic and learned.

Since all paragraphs on treatment are based on CG, only exceptions will be marked as OP or NE.

Treatment models specific for dissociation
Several authors describe treatment models specifically for dissociative children, that overlap in main area's: The earliest information was provided by Silberg & Waters (1998) describing the phases of treating the dissociative child as Engagement, which included stabilization, Trauma Work and Resolution, which included integration.

Waters (2016) also promotes an integration of different theories in treatment of the dissociative child (STAR Theoretical Model). She argues that in order to effectively treat the dissociation, the attachment system of the child, developmental aspects, neurobiology and family system all need to be taken into consideration during the treatment process. Wieland (2017) also describes the importance of working with the parents when treating children.

Wieland (2015) describes the stabilization phase in the treatment of these children as: creating safety, stability in daily life, psycho education, handling triggers. Silberg (2013) presents her phased model (EDUCATE) specifically for treating children with dissociative disorders, which consists of the following components: psycho-education, motivation, diminishing amnesia, affect regulation and attachment, triggers and integration of dissociative states.

Treatment models for complex trauma and dissociation
Other useful treatment models with a broader scope designed for chronically traumatized and dissociative children are useful too. The ARC treatment model developed by Blaustein and Kinniburgh (2010) provides a theoretical framework, the core principles of the interventions, and a guiding structure for providers working with these children and their carers, while recognizing that a one-size-model does not fit all. ARC is designed for children from early childhood to adolescence and their carers or caregiving systems. The main areas that the ARC model focuses on are the three core domains in the life of the child that is specifically impacted by exposure to chronic interpersonal trauma, namely attachment, self regulation and developmental competencies. Trauma Experience Integration, the final building block, integrates the range of skills encompassed in the three core domains to enable the child to build a more coherent and integrated understanding of self.

Struik (2014) describes the Sleeping Dogs method for chronically traumatized children with specific interventions for dissociative children and adolescents. The stabilization phase is structured by six 'tests' (steps): Safety, Daily Life, Attachment, Emotion Regulation, Cognitive Shift and The Nutshell. These tests have a fixed order and a Six Test Form guides clinicians to analyze cases and plan treatment. Each test has a set of interventions that can be used to increase stability if a child does not pass the test directly. The main goal of stabilization is to create enough stability to start trauma processing. After stabilization, the Sleeping Dogs method describes interventions in the trauma-processing phase with the use of EMDR and the integration phase. In the following paragraphs all treatment phases are described for the age groups 4-18 and 0-4 and structured according to the Six Tests (Struik, 2014).

6.1 Stabilization phase 4-18 years

In the stabilization phase emphasis is on helping the child to develop emotional regulation, improve attachment relationships with his[3] primary carer as well as being able to internalize a sense of safety before processing traumatic material.

6.1.1 Psycho education and motivation for both child and carers

Before starting treatment it is necessary to motivate the child and his carers. Usually these children are not motivated to recall their traumatic memories because they can be overwhelmed and they might be trying to 'forget' the traumatic memories. They don't see any advantage in recalling, since they often don't connect their current difficulties, such as extreme anger or anxiety, difficulty concentrating or 'forgetting' of events, to these traumatic memories.
By starting with psycho-education (E in the EDUCATE model, Silberg, 2013) for children from approximately four years and carers about dissociation, dissociative states, the brain, stress regulation, the window of tolerance and attachment, the child will start to understand himself[4] and his own reactions and behavior. Silberg (2013) and Struik (2014) also emphasizes that the children need to know they are responsible for their behavior, despite of which dissociative state was acting out and all the dissociative states need to work together to promote more positive behavior. It is also important that the child understands that no part of the self should be ignored during the therapeutic process and the voices, imaginary friends, the parts of the self and the feelings are reminders of what happened in the past. Psycho-education helps carers and parents to understand the child and his behavior better, which enables them to respond differently. Books, pictures, drawings or metaphors can be used to explain the functioning of the different dissociative states outside the conscious awareness of the child. Basic concepts of neurons and the potential for change in the brain might enable the child to become more motivated to engage in the therapy. Coppens, Snijderberg & Von Kregten (2016) urge that schools and educators of the child also need to receive psycho-education. They might also need a different approach for instance using the metaphor that Coppens et al. (2016) suggested that the child is attending school with an 'invisible suitcase' which contains the trauma.

Silberg (2013) also describes the need to analyze and address the factors that keeps the child tied to dissociative strategies: Dissociation motivation (D in the EDUCATE model). "Engaging in dissociative avoidance strategies has become a habitual way of life for many traumatized children. Their forgetfulness, automatic behaviors, and shifting states keep others at arm's length, and allow them to keep themselves from really facing the results of their actions. Harnessing their motivation to find another way to cope is a huge challenge" (p.70). The child needs hope and should be enabled to develop a future perspective and also understand the reality about the impact on his life, if the trauma and dissociation is not addressed. Areas that might be sustaining the dissociation should also be addressed as early as possible. Waters (2016) states that every behavior has a meaning and the importance of working with this. According to

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Waters, behavior might sometimes be ‘coded and hidden’ and might be a way to externalize the internal world of the child.

6.1.2 Safety

Safety is the first priority when treating traumatized children (AACAP, 2005; ISSTD, 2003, Zeanah, Chesher & Boris, 2016). It makes sense that trauma processing cannot be effective if the child continues to experience new traumatic experiences. In addition to being safe, the child must also feel safe. A threatened child will automatically focus on the world around him to protect himself, which may elicit fight/flight/freeze responses or the need to dissociate. In order to process traumatic memories the child must focus on the inside, which puts him in a vulnerable position. A child can only do that when there is no perceived threat from outside. There are four elements in regards to safety: physical safety, behavioral control, emotional safety and therapeutic safety. Sometimes placement in a residential facility may be necessary in order to achieve this level of control over the child’s behavior. (OP)
Physical safety means that the abuse has stopped. Signs of Safety (Turnell & Edwards, 1999), Resolutions (Turnell & Essex, 2006) or another approach for safety planning with families, are methods that can be used to increase safety for their children.
In addition, the child needs a safe adult that is able to manage the child’s behavior. An adult, who puts the child to bed on time, enables him to go to school and makes sure he will come to therapy regularly is important in the life of the child. If this adult has sufficient authority and control over the behavior of the child it will provide the child with a sense of safety.
A child needs to be supported when facing the difficulties related to his traumatic memories. Emotional safety means that the child has an attachment figure that offers continuity in their relationship. Children without a safe, available attachment figure usually cannot be motivated to access their traumatic memories for trauma processing. Without a consistent and available attachment figure the child can be overwhelmed by emotions and symptoms can worsen. This attachment figure is one of the key elements in treatment.
The last element of safety is therapeutic safety: a child must feel they have permission from their parents to talk in therapy about his trauma experiences. If not, children will find it very hard to do so. A dissociative child can also have a dissociative parent. Then it is even more important to ensure that all the dissociative states of the parent also agree on the child talking and participating in the therapeutic process or that the child has another attachment figure to rely on during treatment. (OP)

6.1.3 Daily life

Besides safety a child also needs stability and predictability in everyday life. When starting trauma processing, he should not encounter new problems that repeatedly need his attention. In addition, the phase of trauma processing takes a lot of energy and can cause a temporary worsening of symptoms. Child and carers should be prepared to cope with it. Otherwise, the child needs to keep his focus on the outside world and is not able to focus on the inside. The problems in daily life that need to be addressed in order to start trauma processing can be identified and worked on, such as sleeping problems, nightmares, intrusions, dissociation, substance abuse, lack of daily routine, eating, school and behavioral problems.

It is important to find out, with child and carers, which situations and which carer or teacher's behavior in daily life triggers the child to react with dissociation. Vice versa it is important to find out which behavior of the child triggers the carers to behave inappropriately towards the child. The child needs to learn to identity triggers and when and why dissociative states appear. The Here and Now exercise (Struik, 2014, pp. 96-97) can help them to gain more control over the dissociation. A Safe Place exercise (Struik, 2014, pp. 94-95) can help the child to calm himself down if the child has already managed a certain level of emotional regulation. Inadequate care or abuse in infancy will have a severe impact on the developing brain (structure and function) and dissociative states appear. Exercises to help the child stabilize in daily life are best repeated and patterned, and focused on soothing and self-regulation (Perry & Dobson, 2013).

Medication is mainly used to reduce problematic symptoms that interfere with daily functioning or to treat comorbid conditions so the child /adolescent can benefit more from therapeutic interventions. There is no specific medication for dissociation but new studies on epigenetically based pharmacotherapy might provide in future more specific treatment options for complex traumatized children. The use of medication differs from country to country depending on specific guidelines (there are countries were off label medication is not permitted to use). Stierum, a Child and Adolescent Psychiatrist, (in Waters 2016) and Nemzer (1998) describe their experiences with the use of off label medication for these children.

6.1.4 Attachment

A child should have an attachment figure that is able to regulate the child's stress and support him during trauma processing. Otherwise the child's stress level can become too high and the child may be overwhelmed or dissociate. Dissociative children often experienced attachment trauma, disorganized attachment by their parents combined with physical and emotional neglect, maltreatment and abuse (Waters, 2016). They have not experienced sensitive attunement from a very young age. For carers these children's reactions can be difficult to understand or sensitively and adequately respond to. A major task is to strengthen the attachment relationship between child and carer (Wieland, 2017). This requires adjustments on both sides: the attachment figure and the child. The therapist needs to manage this process in a skillful way, to incorporate both the parent and the child in the therapeutic process and retain empathy and understanding for both. The therapist also needs to be aware of the transference and counter-transference which might be part of this process (Wieland, 2017).
The first part of the attachment work is focused on improving the attunement of the attachment figure to the child. The parents/carers have to have in mind that very often the child's behavior (or child's states) will reflect the child's interpersonal relationships from the time of traumatization or from his original family and not from the present time. This can help them to become more attuned to the child and regulate stress for the child. The carer has to understand what happens inside the child and be aware of and build a relationship to different dissociative states. The attachment figure must be able to stay calm and put his own needs aside when the child panics, gets angry or is overwhelmed. This can be difficult for parents/carers (attachment figures) who themselves are traumatized or have a dissociative disorder. The child's strong emotions can trigger them and make it very difficult to stay attuned to the child. The attachment figure needs to keep a calm brain in order to be able to adjust his parenting in such a way that the child's attachment system is activated. Some

parents or carers find that very difficult, which is understandable, as the brain of the parent is holding various parenting patterns, which might have to change during this process (Wieland, 2017). Dissociative children usually display different and more extreme behaviors at home than for example in school or towards clinicians, so that the stress, aggression and rejection parents or carers might go through remains unseen and is often underestimated. Many parents or carers feel like they are not understood. If a parent or carer is not able to keep a calm brain it is important to acknowledge that and assist parents or carers to find a solution that is helping the child, but not asking the impossible from parents. It will also be important to enable the parent/carer to build an attachment relationship with all the dissociative states, during the therapy process and also understand that some dissociative states will resist attachment. Sometimes a physical separation between parent/care-givers and the child is necessary to reach that goal.

Because parents or carers are an integral part of the child's therapeutic process, they need to be monitored on a regular basis as well for possibly sustaining secondary trauma. The child's extreme behavior can traumatize a carer and some carers may require trauma treatment themselves. (OP) According to Hughes & Baylin (2010) the clinician needs to co-regulate the negative emotional experiences of the parents first before they are able to be more open to the task of supporting the child to access the trauma. They refer to parents who experience 'blocked care' and move to a defensive mental state where they only focus on the 'badness' of their child's behavior, and not on making sense of the behavior.

Some clinicians involve the parents in the therapy sessions, either selectively or more regularly, in order to enable the parents to have a better understanding of the child's therapeutic process, act as a safe haven for the child during therapy, and/or to be an active part of the child's therapeutic process (Hughes, 2006, Potgieter-Marks, 2015; Waters, 2015). Other clinicians involve the parents in the therapeutic process but not necessarily in the therapy room with the child all the time. Silberg (2013) explains how she will explain information to the child and then invite the parent into the room for the child to explain the information to the parent. It is also important to continue throughout the process to have some sessions with the parents in order to discuss the behaviors of the child and how the parents can manage these behaviors (Wieland, 2015, 2017).

The second part of attachment work focuses on activating the attachment system and promote healthy co- and self-regulation of the child through exercises for the child and attachment figure, practiced in the therapy and repeated daily at home. The main focus during attachment work is to help the parent/carer to regulate arousal and affect with and for the child. A hyper-arousal or hypo-arousal state is a temporary reaction to deal with overwhelming emotions. For a child who experienced complex trauma this state can become more permanent and chronic, even though the child is safe now. The first step in meeting the child is establishing a therapeutic relationship and creating hope. The child needs assurance that he is accepted and being welcome by the clinician the way he is and that the clinician is able to contain frightening memories, overwhelming feelings and even dissociative states that are extremely frightened or needy or show extremely destructive or self- destructive behavior. (OP) Examples of interventions are:

- Body work can help the child to calm down (hyper-arousal) or to activate himself (hypo-arousal): exercises such as jumping on a trampoline, dancing to music the child likes, drumming and breathing exercises, using a 'safe smell', providing chewy food, allow the child to suck from a bottle, sucking lollies help the child to be more grounded , improve emotional regulation and to become more aware of the 'here and now' (Potgieter Marks, 2017).
- The young dissociative states, who are often in a hypo-arousal or hyper-arousal state can be supported through play focusing on eye-gaze communication, safe and nurturing body contact like massage (if the child is able to tolerate it), being rocked in a hammock or being fed. Narratives or self-made songs focusing on resources and being safe can soothe the child. A helpful tool can be the use of a form of video interaction guidance for enhancing attachment (Havermans, Verheule & Prinsen, 2014).
- Dissociative children often are unable to control their rage. Parents/carers need to be trained to stay close to their child and to help him to regulate his rage and calm down. Furthermore they have to set clear boundaries so the child feels contained. The dissociative child needs to learn that he is responsible for destructive behavior even if he is amnesic for what he did. An accepting attitude towards all dissociative states including the angry/rage/violent states will assist the child in starting to accept those states as part of him. Rejection of certain dissociative states or certain feelings strengthens the need to maintain the dissociation in these dissociative states. Parents or carers givers can tell the child in therapy that they accept all dissociative states of the child or write a thank-you note to the protective or angry states of the child. Silberg (2013) refers to Seligman, Steen & Peterson (2005) who identified gratitude as an antidote to depression and a key component of mental health. Gratitude in children is promoted through producing these thank-you notes for all the help that they have given the child at the time of the trauma to their dissociative states.
- As some children display distress at school, they need to have a person at school that they can trust and who is willing to make an emotional connection to the child. Specific interventions can also be introduced in terms of predictability of the school day (visual timetable) and consistent support in school in order to provide an 'attachment' figure for the child in school (Bomber, 2007). Allen (2017) states regarding school "Key adult support is vital to support the child from dysregulating" (p. 208).

6.1.5 Emotion regulation

To enable the child to manage arousal (A in the EDUCATE model), the child needs to be educated about the occurring hyper-arousal and hypo-arousal and the impact on his body. The child has to become aware of bodily sensations and can be taught different techniques to manage arousal. During these arousal experiences, the clinician and carers of the child needs to be attuned to the child in order to help the child regulate the arousal experiences. Then the child will have both inter- and intrapersonal techniques and experiences of co- and self-regulation.

After the child learned to regulate arousal, the child can start learning how to deal with emotions. Obviously the development of emotion regulation skills depends on the child's age. Dissociation is a way to escape from overwhelming emotions. During trauma processing intense feelings such as anger, fear and shame can overwhelm the child to an extent that the child is unable to proceed. The child may dissociate and

loose contact with the clinician. The child may also become too overwhelmed by feelings after the session and use self-harm or substance abuse to regulate the emotions. Therefore, in order to minimize the need for dissociation, dissociative children need extensive emotion regulation work.

Emotion regulation work involves several phases. When children are traumatized in infancy they might have difficulty differentiating emotions and have diminished insight in their emotional life. Moreover, sometimes the underdeveloped emotional life present itself in an autistic manner that can be better understood as neuro-developmental delay.

By exploring somatic sensations, naming them and linking them with the clinician's assistance and supporting parents or carers, the child's emotional awareness may improve. Children with dissociative disorders sometimes have a dissociative state with seemingly no feelings, or states with violent, overwhelming feelings. The latter make the child afraid of feelings in general. The different dissociative states then become afraid of each other. They don't understand the behavior and feelings of the other states. The child must be able to experience and accept all feelings and behaviors. Silberg, (2013) also describes the importance of claiming what is hidden in one self (C in the EDUCATE MODEL). The child has to learn to embrace what their minds tried to reject and avoid. This very often leads to feeling the powerful feelings that the child was unable to feel or manage before and start to make sense of this during therapy.

An explanation about the purpose of the different feelings and behaviors enables the child to learn to better understand his own feelings and behavior. Silberg (2013) explains the importance for the child to understand what is hidden behind the dissociative states (U in the EDUCATE model). This process enables the child to unravel the secret pockets of automatically activated affect, identity and behavioral repertoires that help the child bypass central awareness and engage in avoidance. Next, they need to learn to accept and tolerate emotions and express and regulate them in daily life. Only then they can start accepting and tolerating the old emotions connected to the trauma.

The child needs to be enabled to reflect on all behavior, terrible as it may be, as an attempt to achieve goals, save or support the child. These behaviors were important in the past to enable the child to survive the trauma experiences, but in the present it is causing significant discomfort to the child and/or people around the child. Because the child starts to understand why some dissociative states exhibit terrifying/complex behavior, this behavior becomes less frightening; there is a reason for it, and this makes it more tolerable for the child and parents/ carers. Sometimes the child may hear voices giving him aggressive orders. When the child starts to understand that anger is useful and not bad, and how to deal with anger, he will be more able to accept his own anger. This way you neutralize the child's anxiety, fear or phobia for his own inner world.

6.1.6 Cognitive shift

If the child is intentionally or unintentionally traumatized by a parent or another person having a close relationship with the child, it is important to review the issues in this test. Children often blame themselves for what happened and have cognitions

like ‘it's my fault’ or ‘I'm a bad child’. Through trauma processing these cognitions change and the child needs to make a *cognitive shift* to cognitions like ‘I am not responsible’ or ‘I am a good child’. The child needs to be able to put the responsibility of what happened with the perpetrator (often the parent) without risking to be rejected. It is only then possible for the child to make this cognitive shift. But in order to be able to put the responsibility with that perpetrator (parent), the child needs to know whether the parent acknowledges this, so the child does not have to fear being rejected. If the perpetrator (parent) or the parent who was unable to protect the child, is unable to acknowledge what happened and unable to confirm that it was not the child’s fault or responsibility, children tend to stay loyal and keep feeling responsible themselves. Only when sufficiently attached to another person (non-offending parent, foster parent, adoptive parent or carer) the child could risk being rejected by the perpetrator (parent) and make the cognitive shift anyway.

If one of the parents abused or neglected a child, the other parent is also responsible for not protecting the child. This is a difficult message for non-perpetrators who already feel so guilty. Clinicians are inclined to minimize their guilt or responsibility or even deny it. This can get the child into trouble during trauma processing. By denying that responsibility a role-reversal in the parent-child relationship might remain because the child will maintain the idea that his parent cannot protect him and he needs to protect himself. The child can only start trauma processing when the child knows these cognitive shifts can be safely made (Struik, 2014).
Several things are important in this test. It is crucial to maintain a neutral stance and be accepting towards a perpetrator-parent and always discuss the positive feelings the child might have towards the perpetrator or the positive feeling the perpetrator-parent might have towards his child. Despite of what he or she has done, if a perpetrator displays positive feelings towards his child, it is important to tell the child. If the child feels that the clinician rejects his parent, internal conflicts might rise. It is also important to allow the child to express negative emotions towards the parents if the child needs to do this. This should be done in a safe and contained way. The child must learn to tolerate ambivalent feelings.
A meeting between the clinician and the perpetrator, especially if the child still has contact with the perpetrator, may at times be necessary to discuss to what extent this person can take responsibility. This should only be done with caution and the reassurance that the meeting will not destabilize the child. The child needs to know that the clinician supports the child, since complex traumatized and dissociative children often suffer from betrayal-trauma (Freyd 1994, 1996; Freyd et al., 2005; Freyd & Birell, 2013). Dissociative children easily pickup clinician’s feelings of anger or rejection towards a perpetrator-parents. This must be avoided since this means also rejecting the inner perpetrator-part of the child. And by being too careful about meeting the perpetrator, clinicians can transfer anxiety, so the child feels that the perpetrator, and also his inner-part, is very dangerous. Meeting a perpetrator-parent, hearing his story and telling him about his child and explaining the impact of trauma on the child’s cognitions can lead to a perpetrator taking more responsibility. This information can be used to inform the child about his parent’s views and the consequences of making a cognitive shift. The parent can do that in for example a letter or video, or the clinician can tell the child about the conversation he had with that parent. With this information the child can estimate the risk of rejection by his parents or family when he would start talking about traumatic memories (Struik, 2014).

6.1.7 Nutshell

A chronically traumatized child has many traumatic memories that need to be processed one by one. Therefore the child must be able to control the activation and deactivation of his memories to some extend. The child must be able to list or at least summarized the main traumatic memories without being too disrupted. If the child gets overwhelmed doing this, more work needs to be done on the previous tests. Dissociative children often don't remember all traumatic experiences at once. Often after processing some memories, others occur. Techniques that can be used are:

- Imagery work with a Safe Deposit Box (Struik, 2014) or Safe Haven.
- The Screen technique (Adler-Tapia, & Settle, 2008; Besser, 2011; Struik, 2014) can be practiced so it can be used during the phase of trauma processing. It is a therapeutic tool, adapted from the tradition of clinical hypnosis, which strives to give the child maximum control while processing traumatic material. The child experiences himself in the position of an observer and projects a traumatic experience as movie on an imaginary screen. The child determines which dissociative states are invited to look at the traumatic memory and which dissociative states stay in a safe place. Positive memories or favorite photo's can serve as screensaver the child can use when he starts feeling overwhelmed (Huber, 2011).

6.2 Trauma processing phase 4-18 years

For adults it is advised that trauma processing occurs in the mid-phase of treatment after a course of stabilization. If processing is done too soon it may destabilize adult survivors, leading to hospitalization, self-injury and regression. However, with children and adolescents, this recommendation needs to be reevaluated for each child's unique situation. It is important to recognize that children and adolescents have not had as much opportunity to develop the intense avoidant defenses and phobia to traumatic content in the way that adults have done (Silberg, 2013; Struik, 2014).

During this phase of the therapy, the child also needs to understand triggers and be enabled to process the trauma (T in the EDUCATE model). The child also needs to process the intense feelings of fear, abandonment, rejection, shame and anxiety that might still be dictating the child's perception of him. During the trauma processing there will be specific focus on somatoform dissociation as well as dissociative states that might be causing risk-taking behaviors, self-harming or violent and sexualized behaviors. These dissociative states might be more complex to work with but integration of these dissociative states usually brings significant relief for the child and adults around the child.

Eye movement desensitization and reprocessing (EMDR) can be used to process traumatic experiences. EMDR is an evidence-based method for treating PTSD suitable for children from infanthood. EMDR does not require a lot of verbal abilities, which are usually underdeveloped in dissociative children. Levine & Kline (2007) state that EMDR seems to have better access to dissociative states than CBT, as the cortex is often not accessible or available during recall of trauma.
Hypnoses or Guided Syntheses, used for adults with dissociative disorders, is not commonly used for children with dissociation. Symbol Drama could be a promising (small pilot study) psychotherapeutic method with for adolescents where the

adolescent is in a relaxed state and works under the guidance of a clinician with pictures and daydreams (Nilsson, 2007; Nilsson & Watsby, 2010). Progressive Counting could be a promising (small pilot studies) method embedded within phase model of trauma-informed treatment (Greenwald, 2013).

In clinical practice experienced practitioners using EMDR start trauma processing as early as possible after stabilization because it relieves symptoms rapidly if dissociation is co-morbid to PTSD or complex PTSD. With children with severe structural dissociation and an already poly-fragmented sense of self, EMDR, as well as other methods, can be used, but with caution. The following interventions can be added to the use of EMDR/bilateral stimulation for trauma processing with children:

- Working with a Timeline to enable the child to have a better understanding of the past trauma and process painful events (Wieland, 2015).
- Using the imaginary protective shield which will protect the child (Waters, 2016)
- Any activity that can enable the child to achieve mastery over the emotion, behavior or problem after the original trauma processing (Adler Tapia, 2012).
- Drawings and discussion of drawings where the focus is on the trauma experiences (Wieland, 2015)
- Play Therapy about the traumatic event (Potgieter-Marks, 2017)
- Symbols depicting the trauma experience
- Sand tray portraying the traumatic experience (Potgieter-Marks, 2017)
- Using puppets (Waters, 2012)
- Rescue-fantasies (Waters, 2012)
- Placing any unprocessed memory or threatening memories in a container to process it safely (Waters, 2016)
- Sensory-motor activities (Waters, 2016, Potgieter-Marks, 2017)
- Creating safe spaces for dissociative states in order to contain them for a period of time (Waters, 2016)
- Creating a safe space or ‘Anger Room’ to contain any aggressive or violent states to be contained.

Traumatic memories can be embedded in a framework of memories of when the world was still fine, directly before the traumatic experiences (this is only possible if the child ever had any sense of safety before the onset of the trauma) and memories of where the child felt some safety again after the traumatic experiences. These memories can function as ‘emotional anchor’ at the end of the traumatic movie, which can be used during the Screen Technique. In between these frames the child is encouraged to project the traumatic event as ‘old movie’ on the screen and is supported to look at what happened ‘piece by piece’. The aim is to get the child, who is normally stuck in confusion, orientated to what happened in the past. An imaginative remote control helps the child to regulate his affects and arousal. The child can pause, wind or rewind the movie. He can zoom in or out. By repeatedly playing the movie, the child can work through his traumatic memories by focusing on his emotions, his sensations and cognitions. Special important areas might be highlighted and may be looked at in detail.

There are some specific issues for the use of EMDR with children with dissociative disorders:

- It is advisable to use eye movements during EMDR; this makes it easier for the clinician to see if the child is dissociating and allows the clinician to have more

control of the process. Young children find it easier to concentrate on fingers if the clinician wears finger puppets. Some traumatized children might have problems with fixation and tracking of the eyes due to physical problems, or early neglect and trauma. In these cases various types of BLS can be used like tapping or buzzers (Adler-Tapia & Settle, 2008) in combination with drawings, story-telling, sand tray, relevant books can assist the child in processing trauma.

- In cases of dissociative disorders it may be necessary to actively involve the various dissociative states. This also depends on co-consciousness of the child. The older a child gets, the more powerful the amnestic barrier might be between the different dissociative states. Different self-states might hold a different perception of the trauma and each self-state need an opportunity to process their traumatic experience (Waters, 2016).
- EMDR can activate memories and other dissociative states and induce enactment of traumatic memories. A child can for example temporarily become more angry, sadistic or sexually active. This should be monitored and labeled as progression instead of regression.
- Questions (cognitive interweaves) like 'What is the boy or girl doing there?', 'Who is with her?', 'What does he look like?', 'What happens then?' can be asked. The clinician may help the child to differentiate between past and present.
- Resource Development and Installation (RDI) (Adler Tapia, 2012) can be used very effectively in dissociative children in order to install sufficient resources before, during and after trauma processing.
- Traumatic material can be enacted in play. Trauma processing while playing can be easily introduced. The child re-enacts parts of his traumatic experiences in the sand tray with human or animal figures, in the doll's house with puppets, or in role-plays with hand puppets or stuffed animals. In these plays different figures/puppets/animals may symbolize different dissociative states. They may carry dissociated feelings, special memories, different body states and cognitions. The clinician can ask for feelings of the single figures, their cognitions about themselves or about the world, their body sensations to support the child in realizing what the different figures stand for. The clinician may encourage the child to let single figures talk to each other so that a process of 'getting to know each other' and internal communication and integration may start. Moreover the clinician can use his knowledge about the trauma history of the child and link it to what the child is re-enacting in his play. Clinicians trained in EMDR can support processing during play by adding BLS. (OP)

It is also important for clinicians using EMDR to know that severely dissociated children and adolescents not necessarily will, or can, let all dissociative states be present during the treatment. There might be an ongoing dissociation and some dissociative states might experience EMDR (as well as other methods) as scaring and upsetting. Often not all aspects of the traumatic memory, behavior, affect, sensory motor, knowledge (BASK model by Braun, 1988), are processed at the same time. Trauma processing usually takes place in layers. The child will process some memories, than stabilize again and work on attachment. A few month later new memories or other aspects of the same memory might occur and has to be processed. It is important to note that if the child is starting to produce repetitive experiences or activities, it might indicate that the child is unable to process the trauma at that time and the child is in fact 'looping' in the traumatic experience (Potgieter Marks, 2017). Therapists need to be aware of the fact that children also have the capacity to avoithe

trauma experiences and thereby use the therapy to dissociate in a fantasy world instead of actively processing the trauma. This appears to be more prevalent in inexperienced therapists only using unstructured therapies where the traumatised child directs the therapy and at the same time avoiding the trauma information (Potgieter-Marks, 2017). In order to still use these activities and ensure that trauma processing does occur, some clinicians prefer to use continuous bilateral stimulation (BLS)[5] during these activities. This can be done through walking, marching, drumming or any other bilateral activity. (OP)

Parents or carers must be informed of the effect trauma processing can have on the child. Regression is often seen and should be allowed and labeled as progression. It is important to also consider that the regressive state may be an emerging dissociative part (Waters, 2005). (GC)

6.3 Stabilization phase 0-4 years

For young children the stabilization phase can be much shorter than with older children. Traumatic memories can trigger anxiety around attachment and block the deepening of attachment relationships. By processing these traumatic memories as soon as possible, attachment relationships can improve and children start to develop rapidly in all developmental areas. Information from parents, family, foster parents, the child, carers, triggers, the child's reactions, scarring, bodily harm or the child's file can be used to create a story about possible and certain traumatic experiences. A doll, soft toys, pictures of a hero, being in the arms of the attachment figure can provide additional reassurance. Calming music, a reassuring or calming smell (lavender) or blanket (touch) can help to overcome over-modulated or under-modulated emotional states.
The minimum requirements are:

- The abuse must have stopped.
- The child must have an attachment figure that can come with him to the sessions and is stable enough to be attuned to the child. This preferably is a permanent carer, but trauma processing can be done with a temporary attachment figure as well, since living with a family for a few months can seem forever to a young child.

6.4 Trauma processing phase 0-4 years

The use of trauma-focused interventions that emphasises the attachment system as a foundation on which to base clinical intervention is critical in the recovery of young children affected by complex trauma (Osofsky, 2004). With young children trauma processing is always combined with psycho education of parents and attachment work. Young children tend to process memories in layers. Often the attachment relationships deepen after trauma processing. That might activate new memories or other aspects of memories and the child may need more trauma processing. Parents and carers should be instructed to be 'watchful waiting' and seek further trauma-processing therapy if further dissociative behavior occurs.

[5] Bilateral Stimulation is a technique used in EMDR

For children under four the EMDR technique Story Telling (Lovett, 1999) is used to activate traumatic memories. The trauma narrative describes the different levels that need integration: the behaviour the child displays presently that refers to the feelings, sensations, cognitions the child had or may have had during the traumatic event. The carer, parent or clinician tells the trauma story, with the child on the carers lap, while the EMDR clinician applies BLS. Children who have traumatic experiences in the preverbal phase frequently have few, or no conscious memories. Many young children are also able to provide significant information, although in a fragmented way that can also be used to process their trauma. Young children often express their distress through their bodies and by reflecting what the body is doing, the child gains a better understanding of his internal world. The clinician can also reflect on the body's responses while doing EMDR in order to enable the young child to process the sensory experiences of traumatic memories. With young children BLS such as 'tapping' or using the 'buzzers' or other forms of playful BLS is used instead of eye movements.
Specific models of child-parent psychotherapy are: the well validated dyadic model for modulation of emotional states CPP (Van Horn & Lieberman, 2008), parent-child interaction therapy (Ford & Gurwitch, 2008) or family systems therapy (Ford & Saltzman, 2009) used when siblings potentially suffer from the deregulated child.
In clinical practice interventions like play therapy, art therapy, drawings, paintings and role-play are used to enable trauma processing. With younger children specifically, it is advisable to ensure that they do not use fantasy play in order to avoid trauma experiences. Some aspects or characters in the play, drawings, painting, and role-play might have to be specifically explored as it might represent dissociative states.

Some children might also provide information during trauma processing about their intra-utero traumatic experiences. If this occurs, it is important to also explore and process these traumatic experiences (Potgieter-Marks, 2016).

6.5 Integration phase

Silberg (2013) describes Integration as part of the Ending stage in the (E) EDUCAT*E* model. Waters (2016) also discusses different examples of integration in children. The ending phase should also be used to enable the child to acquire the competencies needed for age appropriate behavior.

For children with dissociative disorders integration means accepting all the dissociative states as part of themselves. Trauma processing is completed when a child with a dissociative disorder realizes that he *himself* has had all these experiences (personification) and that they are experiences from the *past* (presentification) (Van der Hart et al., 2006). The child's explanation was initially: 'this is so bad, it can't have happened to me, so it must have happened to someone else.' That is how splitting of the personality occurs. For these dissociative states of the personality the traumatizing circumstances are not in the past, but feel real, in the here and now. After processing the traumatic memories and integrating all dissociative states of the personality, they realize that they are in the present tense and their traumatic experiences lie in the past. The child can make some sense of the experiences and combine all his experiences into the autobiographical memory. There can be a period of grief and loss for the lost childhood (Waters, 2016)

The child has learnt important lessons from these experiences and discarded the information that was not relevant. The child has learnt to give meaning to what he has experienced. The child has found an explanation for what happened and what this means to him personally. Furthermore the child must learn to live with both positive and negative feelings, thoughts, and wishes. The child must be able to tolerate inner conflicts and learn to deal with contradictory thoughts and emotions. The black-and-white thinking, which is typical for traumatized children, is the opposite of integrated thinking and tolerating ambivalence. Therapy can be continued to assist the child to integrate his new knowledge in his reality after integration.

Dissociative states which demonstrate behavior inappropriate in the child's life, need to realize that the 'danger is in the past'. These dissociative states need to be encouraged to adapt to a new role now (Waters, 1998, 2016), which will enhance the child's present life, behavior and performance. Though the perpetrator dissociative state may show as extremely destructive or self-destructive, his primary function as supporter of the abused or maltreated child needs to be appreciated, although in some cases this might not be possible (Potgieter-Marks, 2012a; Potgieter-Marks, 2012b).

After trauma processing, spontaneous integration may take place. If the spontaneous integration of a dissociative state has not taken place, it will be necessary to help the child with this by specifically focusing on integrating this dissociative state. Through internal communication the child can change the name and the function of the dissociative state to adapt to a more acceptable role. Integration can also be explained with metaphors like a soccer team. The team can only win when all parts of the team work together. Activities supporting the process of integration are: visual experiences (i.e. the painting of a rainbow in which several colors flow together) or tactile experiences (i.e. taking different colors of clay and building a ball out of it) whereby each color symbolizes a single part, fusion rituals or figures in the sand tray symbolizing the different dissociative states come closer, hold hands (Waters, 1998). Waters (2016) describes symbolic drawings of integration as well as the use of EMDR during the integration of dissociative states.

Integration is successful when traumatic memories are not overwhelming anymore, somatic symptoms have lessened, affect regulation improved and a new cognitive understanding is gained. The child is able to take more control over himself and his behavior and no longer experiences himself as 'out of control'. There is also usually significant improvement in symptoms as objectively confirmed by the adults caring for the child.

7. Residential/ inpatient treatment

Outpatient treatment is first choice for the treatment of dissociative children and especially adolescents, to prevent regression and maintain what is going well. Since inpatient facilities differ from country to country in Europe only general considerations are described in the paragraph. Inpatient treatment, in a youth care facility or a mental health ward, can be necessary if the child's familiar surrounding is not stable enough to support the child with his inner conflicts and struggling during the therapeutic process. For example if the child shows aggressive, sexually aggressive, destructive or self-destructive behaviour that is too overwhelming or

unsafe either for himself or his surrounding. Treatment in a residential facility or inpatient unit can sometimes be a relief for a dissociative child. The intimacy of a family can be a constant source of stress that is not recognized. After placement functioning often improves, especially in the age six to twelve years. But there is a great risk of hospitalization when these children do not have an attachment relationship with an adult attachment figure that offers continuity of the relationship. This attachment relationship is needed to overcome the dissociative symptoms eventually and heal from dissociation. After that, placement in a family setting might slowly be introduced and might be possible. (OP)

8. Length of treatment

The stabilization phases for children can be very diverse. Sometimes a child needs extensive work, sometimes on a few aspects and sometimes only on one area. Age is a strong determining factor. Very young children don't need much stabilization and their stabilization phase can be very short, if they have a safe attachment figure to rely on. Children between six and twelve years need some more stabilization, usually several months. Adolescents often need much more work and their stabilization phase can extend to more than one year. Treatment may involve individual therapy sessions with a child, sessions with the child and his parents or carers and at times with the parents or carers alone. Therapy can be combined with family therapy and/or support for the parents/carers. Children might be vulnerable to new problems when mastering new developmental steps, especially entering adolescence. Further therapy can support them through these steps.

9. Organised Abuse

An increasing amount of children are providing information that they were victims, of organized abuse. These children and adolescents are amongst the most traumatised group of children and they might need more intensive treatment, which is adapted to address their specific need in order to enable them to recover.

10. Clinician

Dissociative children do not trust adults, as they have attachment disturbances and very often are sufferers of betrayal-trauma (Freyd 1994, 1996; Freyd et al, 2005; Freyd & Birell, 2013). A clinician needs a secure enough carer as a co-clinician, because the child will tell more about his inner world to them than to the clinician. Because these children do not integrate worlds themselves and tend to separate, it is more beneficial to work with someone involved in the child's daily life. People who work with these children can experience extreme and intense feelings of panic, hate, sadism, sadness, attachment need, rejection, worthlessness or feeling not important. Clinicians working with dissociative children need to have access to (peer) supervision and consultation on a regular basis on trauma-related transferences and parallel-processes to prevent vicarious traumatization. Especially feelings of helplessness and powerlessness that dissociative children experienced and sometime still experience, can be transferred and lead to vicarious traumatization.

11. Conclusion

It becomes increasingly evident that professionals involved with traumatised children are searching for answers on how to treat this complex population of children. These guidelines should provide at least significant information about the assessment and treatment process and can also provide direction for therapists in terms of the literature available. Children and adolescents can be treated for complex trauma and dissociation with good outcomes and significant recovery.

12. References

Achenbach, TM & Rescorla, LA. (2007). *Manual for the ASEBA School Age Forms and Profiles*. Burlington: ASEBA.

Adler-Tapia, R. & Settle, Carolyn (2008*). EMDR and the Art of Psychotherapy with Children.* New York: Springer Publishing Company, LLC.

Adler-Tapia, R. (2012). *Child Psychotherapy: Integrating Developmental Theory into Clinical Practice.* New York: Springer Publishing Company, LLC.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186.

Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. (2012). Understanding Interpersonal Trauma in Children: Why We Need A Developmentally Appropriate Trauma Diagnosis. *American Journal of Orthopsychiatry, 82*(2), 187-200.

Arvidson,J. Kinniburgh, K., Howard, K., Spinazzola., Strothers, H., Evans, M., Andres, B., Cohen, C., Blaustein, M.E. (2011). Treatment of Complex Trauma in Young Children: Development and Cultural Considerations in Application of the ARC Intervention Model. *Journal of Child & Adolescent Trauma*, *4*(1), 34-51.

Armstrong, J., Putnam, F.W., Carlson, E., Libero, D., & Smith, S. (1997). Development and validation of a measure of adolescent dissociation: The Adolescent Dissociative Experience Scale. *Journal of Nervous & Mental Disease*, 185, 491-497.

Barach, P. (1991). Multiple personality as an attachment disorder. *Dissociation,* 4, 117-123.

Baita, S. (2015a). Dalma (4-6 years old).“I’ve Got All My Sisters With Me”.Treatment of Dissociative Identity Disorder in a Sexually Abused Young Child. In S. Wieland (Ed.), *Dissociation in Traumatized Children and Adolescents – Theory and Clinical Interventions* (2nd ed.) (pp. 41-88). London: Routledge.

Baita, S. (2015b) *Rompecabezas: Unaguíaintroductoria al trauma y la disociación en la infancia*. Amazon: CreateSpace.

Besser, L.U. (2011). Screen Technik 1, UnveröffentlichesManuskript, *Curriculum fürPsychotraumatologie.*

Blaustein, M. &Kinniburgh, K. (2010). *Treating Traumatic Stress in Children and Adolescents.* Guilford. New York

Bomber, L.M. (2007). *Inside I’m Hurting. Practical strategies for supporting children with attachment difficulties in schools.* London: Worth Publishing.

Braun, B. G. (1988). The BASK model of dissociation. *Dissociation, 1*, 2, 4-23.

Brand, B. L.; Armstrong, J. G.; Loewenstein, R. J.; McNary, S. W. (2009). Personality differences on the Rorschach of dissociative identity disorder, borderline personality disorder, and psychotic inpatients. *Psychological Trauma: Theory, Research, Practice, and Policy,* 1(3), 188-205

Briere, J. (1996). *The Trauma Symptom Checklist for Children.* Odessa, FL: Psychological Assessment Resources.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., & Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect, 25*, 1001-1014.

Brisch K.H. (2012) *Treating Attachment Disorders. From Theory to Therapy*. New York/ London: The Guilford Press

Brunner, R., Parzer, P., Schuld, V., &Resch, F. (2000). Dissociative symptomatology and traumatogenic factors in adolescent psychiatric patients. *Journal of Nervous & Mental Disease*, 188, 71-77.

Carlson, V., Cicchetti, D., Barnett, D. & Braunwald, K. (1989) *Developmental Psychology, 25*(4), 525-531. http://dx.doi.org/10.1037/0012-1649.25.4.525

Carrion, V. G., & Steiner, H. (2000). Trauma and dissociation in delinquent adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *39*(3), 353-359.

Coons, P.M. (1996). Clinical phenomenology of 25 children and adolescents with dissociative disorders. *Child & Adolescent Psychiatric Clinics of North America*, 5, 361-374.

Coppens, L., Schneijderberg, M. & Van Kregten, C. (2016). Lesgeven aan getraumatiseerde kinderen. Amsterdam:Uitgeverij SWP.

Draijer N. & Langeland W. (1999). Childhood trauma and perceived parental dysfunction in the etiology of dissociative symptoms in psychiatric inpatients. *Am J Psychiatry,* 156(3), 379-85.

Dell, P.F., & Eisenhower, J.W. (1990). Adolescent multiple personality disorder: A preliminary study of eleven cases. *Journal of the American Academy of Child & Adolescent Psychiatry, 29*, 359-366.

Farrington, A.D., Waller, G.D., Smerden, J.D., &Faupel, A.W. (2001). The Adolescent Dissociative Experiences Scale: Psychometric properties and difference in scores across age groups. *Journal of Nervous and Mental Disease*, 189, 722-727.

Ford,J. (2009). Neurobiological and Developmental Research. Clinical Implications. In C. Courtois & J. Ford (Eds.), *Treating Complex Traumatic Stress Disorders. An Evidence-Based Guide* (pp 31-58). Cambridge: Cambridge University Press.

Ford J., & Courtois, C. (2013). *Treating Complex Traumatic Stress Disorders in Children and Adolescent.* New York: Guilford Press.

Freyd, J. J. (1994). Betrayal-trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behavior, 4,* 307-329.

Freyd, J. J. (1996). Betrayal trauma: The logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.

Freyd, J. J., & Birrell, P. J. (2013). *Blind to Betrayal: Why we fool ourselves we aren't being fooled.* Somerset, NJ: Wiley.

Freyd, J. J ., Klest, B., & Allard, C. B. (2005). Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. *Journal of Trauma & Dissociation, 6*(3), 83-104

Gerge, A. (red.) (2013). *Vad har du varit med om? PTSD och dissociation hos barn och unga. Förekomst, diagnostik och behandling*. Stockholm: Insidan.

Greenwald, R. (2013). *Progressive counting within a phasemodel of trauma-informed treatment*. New York: Routledge.

Havermans, A., Verheule, C & Prinsen, B. (2014). *Gehechtheid in Beeld. Handleiding video-interactiebegeleidingvoorprofessionals in de adoptienazorg.* Amsterdam: BV Uitgeverij.

Herman, J.L. (1992). *Trauma en recovery*. New York: Basic Books

Hornstein, N.L., & Putnam, F.W. (1992). Clinical phenomenology of child and adolescent dissociative disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 31, 1077-1085.

Huber, M. (2011). *VieleSein. EinHandbuch. Komplextrauma undIdentität-verstehen, verändern, behandeln*. Paderborn: Jungfermann.

Hughes, D. (2006). *Building the Bonds of Attachment – Awakening Love in Deeply Troubled Children*. New York/Oxford: Jason Aronson.

Hughes, D. & Bailin, J. (2012). *Brain Based Parenting: The Neuroscience of Caregiving for Healthy Attachment.* New York/London: W.W. Norton & Company.

Kassam-Adams, N. (2006). The Acute Stress Checklist for Children (ASC-Kids): Development of a Child Self-Report Measure. *Journal of Traumatic Stress*, 19(1), 129–139.

Lanius, R. A., Vermetten, E., Loewenstein, R. J., Brand, B., Schmahl, C., Bremner, J. D., & Spiegel, D. (2010). Emotion modulation in PTSD: Clinical and neurobiological evidence for a dissociative subtype. *The American journal of psychiatry*, *167*(6), 640-647.

Levine, PA & Kline, M. (2007). *Trauma Through a Child's Eyes*. Colorado: Ergos Institute Press.

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

Liotti, G. (2006). A model of dissociation based on attachment theory. *Journal of Trauma & Dissociation*, 7, 55-74.

Liotti, G. (2009). Attachment and Dissociation. In: P. Dell & J. O´Neil (Eds.), *Dissociation and the Dissociative Disorders. DSM-V and Beyond*. (pp.53-65). New York, London: Routledge Press.

Lovett, J. (1999). *Small Wonders: healing childhood trauma with EMDR.* New York: Free Press.

Ludy-Dobson, C. R., & Perry, B. D. (2010). The role of healthy relational interactions in buffering the impact of childhood trauma. In Gil (Ed.), *Working with children to heal interpersonal trauma: The power of play. (*26-43). New York: Guilford Press.

Mann, B.J., & Sanders, S. (1994). Child dissociation and the family context. *Journal of Abnormal Child Psychology, 22*, 373-388.

Nemzer, E. (1998). Psychopharmacological interventions for children and adolescents with dissociative disorders. *The dissociative child: Diagnosis, treatment & management (2nd ed., pp. 231-272). Lutherville, MD: Sidran.*

Nijenhuis, E. (2012). Fantasy proneness in dissociative identity disorder**.** *ONE 7(6), e39279. doi:10.1371/journal.pone.0039279. Supporting information S1.*

Nilsson, D. (2007). *Trauma, Posttraumatic Stress and Disociation Among Swedish Adolescents.Evaluation of Questionnaires.* Linköping: Linköping University Medical Dissertations No 979.

Nilsson, D., & Wadsby, M. (2010). Symboldrama, a psychotherapeutic method for adolescents with dissociative and PTSD symptoms: A pilot study. *Journal of Trauma and Dissociation* 22, 308-321.

Ogawa, J.R., Sroufe, L.A., Weinfield, N.S., Carlson, E.A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development & Psychopathology*, 9, 855-979.

Osofsky, J. D. (2004). *Young children and trauma: Intervention and treatment*. New York: Guilford Press.

Perry, B.D. (2006). The Neurosequential Model of Therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children. In N. Boyd Webb (Ed.), *Working with Traumatized Youth in Child Welfare* (pp.27-52). New York, NY: Guilford.

Perry, BD. (2009). Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. *Journal of Trauma and Loss,* 240-255

Perry, B. D., & Dobson, C. L. (2013). The neurosequential model of therapeutics *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models* (pp. 249-260). New York, NY: Guilford.

Potgieter-Marks, R. (2012a).Täterintrojekte in der Behandlung von dissoziativen Kindern. In :Vogt, R. (Hrsg.) *Täterintrojekte: Diagnostische und therapeutischeKonzeptedissoziativerStrukturen* (pp. 139-160) Kroning: AnsangerVerlag

Potgieter-Marks, R. (2012b). When the Sleeping Tiger Roars – Perpetrator Introjects in Children. In R. Vogt, (Ed.), *Perpetrator Introjects – Psychotherapeutic Diagnostics and Treatment Models* (pp. 87 – 110). Kroning: AnsangerVerlag

Potgieter-Marks, R. (2015). Jason (7-Years Old) – Expressing Past Neglect and Abuse: Two –Week Intensive Therapy for an Adopted Child with Dissociation. In S. Wieland (Ed.), *Dissociation in Traumatized Children and Adolescents – Theory and Clinical Interventions.(*2nd Ed.) (pp. 89-134). London: Routledge.

Potgieter-Marks, R. (2016) Pre-Birth Trauma – The Missing Link in Full Recovery? *ESTD Newsletter*, 5(4), pp16-23.

Potgieter-Marks, R. (2017). When Play Therapy is not Enough: Using EMDR in combination with Play Therapy with Complex Trauma in Children. In: Hendry, A & Hasler, J. *Creative Therapies for Complex Trauma: Helping Children and Families in Foster care, Kinship care or Adoption.*(pp.164-180) London: Jessica Kingsley Publishers.

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

Putnam, F.W., Helmers, K., &Trickett, P.K. (1993). Development, reliability and validity of a child dissociation scale. *Child Abuse & Neglect*, 17, 731-742.

Putnam, F.W., & Peterson, G. (1994). *Further validation of the Child Dissociation Checklist.Dissociation,* 7, 204-211.

Reinders, A., Nijenhuis, E., Paans, A., Korf, J., Willemsen, A. and den Boer, J. (2003). One brain, two selves. *NeuroImage.* 20(4), 2119–2125.

Reinders, A., Nijenhuis, E., Quak, et al. (2006). Psychobiological characteristics of dissociative identity disorder: A symptom provocation study. *Biological Psychiatry,* 60(7), 730-740.

Reinders, S., Willemsen, A., Vos, et al. (2012). Fact or Factitious? A Psychobiological Study of Authentic and Simulated Dissociative Identity States.*PLoS ONE*. 7(6): e39279.

Saigh, P.A., Yasik, A.E., Oberfield, R.A., Green, B.L., Halmandaris, P.V., Rubenstein,H., Nester, J., Resko, J., Hetz, B., &McHugh, M. (2000). The Children's PTSD Inventory: Development and reliability. *Journal of Traumatic Stress*, 13, 369-380.

Sar, V., Önder, C., Kilincaslan, A., Zoroglu, S. S., & Alyanak, B. (2014). Dissociative identity disorder among adolescents: Prevalence in a university psychiatric outpatient unit. *Journal of Trauma & Dissociation*, *15*(4), 402-419.

Schlumpf, Y. R., Nijenhuis, E. R., Chalavi, S., Weder, E. V., Zimmermann, E., Luechinger, R., ... &Jäncke, L. (2013). Dissociative part-dependent biopsychosocial reactions to backward masked angry and neutral faces: An fMRI study of dissociative identity disorder. *Neuroimage: Clinical*, *3*, 54-64.

Schore, A. N. (2009). Relational trauma and the developing right brain. *Annals of the New York Academy of Sciences*, *1159*(1), 189-203.

Seligman, M.E.P., Steen, T.A., Park, N & Peterson.C (2005). Positive Psychology Progress: Empirical validation of interventions. *American Psychologist*, 60, 410-421.

Silberg, J. (1998). Dissociative symptomatology in children and adolescents as displayed on psychological testing. *Journal of personality assessment*, *71*(3), 421-439.

Silberg, J.& Dallam,S. (2009). *Dissociation in Children & Adolescents*. In: P. Dell & J. O´Neil (Eds), *Dissociation and Dissociative Disorders: DSM-V and beyond.* (pp. 67 - 81). New York: Routledge.

Silberg, J. (2013). *The Child Survivor: Healing Developmental Trauma and Dissociation.* New York: Routledge

Smith, S.R., & Carlson, E.B. (1996). Reliability and validity of the AdolescentDissociative Experiences Scale. *Dissociation*, 9, 125-129.

Steinberg, M. (1994). *The Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D), second edition*. Washington, D.C., American Psychiatric Press.

Stien, PT & Kendall, J. (2004). *Psychological Trauma and the Developing Brain*. London: The Hayworth Maltreatment and Trauma Press.

Stierum, A.J. (2016) Medication as an Intervention in the Treatment of Dissociative Disorders and Complex Trauma with Children and Adolescents. In: Waters (2016), *Healing the Fractured Child: Diagnoses and Treatment of Youth with Dissociation* (pp 249-282*)*. New York: Springer Publishing Company.

Stolbach, B. C. (1997). *The Children's Dissociative Experiences Scale and Posttraumatic Symptom Inventory: rationale, development, and validation of a self-report measure* (Doctoral dissertation, University of Colorado).

Stolbach, B. (2005). Psychotherapy of a Dissociative 8-Year-Old Boy Burned at Age 3. *Psychiatric Annals* 35:8, 685–694.

Struik, A. (2014). *Treating Chronically Traumatized Children. Don't let sleeping dogs lie!* London: Routledge.

Turnell, A. & Edwards, S. (1999). *Signs of Safety: a solution and safety oriented approach to child protection casework.* New York: Norton.

Turnell, A. & Essex, S. (2006). *Working with denied child abuse: the resolutions approach.* Berkshire: Open University Press.
Van der Hart, O, Nijenhuis, ERS & Steele, K. (2006). *The Haunted Self – Structural Dissociation and the treatment of chronic traumatisation.* New York: Norton & Company.
Van der Kolk, B. A. (2005). Developmental. *Psychiatric Annals*, *35*(5), 401.
Van Dijke, A., Van der Hart., Ford, J., O, Van Son, M.J.M., Van der Heijden, P.G.M. &Bühring, M. (2010). Affect dysregulation and dissociation in borderline personality disorder and somatoform disorder: Differentiating inhibitory andexcitatory experiencing states. *Journal of Trauma and Dissociation, 11,* 424-443.
Van Dijke, A., Ford, J. D., van der Hart, O., Van Son, M. J., Van der Heijden, P. G., & Bühring, M. (2011). Childhood traumatization by primary caretaker and affect dysregulation in patients with borderline personality disorder and somatoform disorder. *European journal of psychotraumatology*, *2*(1), 5628.
Van Dijke, A., Ford, J.D., Frank, L., Van der Hart. O. (2015). Association of Childhood Complex Trauma and Dissociation with Complex PTSD Symptoms in Adulthood. *Journal of Trauma and Dissociation, xx.*DOI**:** 10.1080/15299732.2015.1016253.
Van Horn, P., & Lieberman, A. F. (2008). Using dyadic therapies to treat traumatized young children. *Treating traumatized children: Risk, resilience and recovery*, 210-219.
Vinkers, C. H., Kalafateli, A. L., Rutten, B. P., Kas, M. J., Kaminsky, Z., Turner, J. D., & Boks, M. P. (2015). Traumatic stress and human DNA methylation: a critical review. *Epigenomics*, 7(4), 593-608. doi: 10.2217/epi.15.11.
Waters, F.S., (1998) *Promoting Integration in Dissociative Children*. In: Silberg (Ed.), *The Dissociative Child: Diagnosis, Treatment and Management* (pp. 167-190). Baltimore: Sidran Press.
Waters, F.S. (2005). Recognizing Dissociation on Pre-School Children. *ISSTD News,* 23, 4, July/August.
Waters, F.S. (2015). Ryan (8 -10 Years Old) – Connecting with the Body. Treatment of Somatoform Dissociation (Encoprecis and Multiple Physical Complaints) in a Young Boy. In S. Wieland (Ed.), *Dissociation in Traumatized Children and Adolescents – Theory and Clinical Interventions* (2nd Ed.) (pp. 135-190). London: Routledge.
Waters, F.S. (2016) Healing the Fractured Child: Diagnoses and Treatment of Youth with Dissociation. New York: Springer Publishing Company.
Walker, AG, (1999). *Handbook on Questioning Children*. Washington DC: ABA Center on Children and the Law.
Watkins, H.H. (1978). Ego state therapy. In: J. G. Watkins (Ed.), *The therapeutic self.* New York: Human Sciences.
Watkins, JG & Watkins, H.H. (1993). *Ego-state therapy in the treatment of dissociative disorders.* In R. Kluft & G. Fine (Eds.), *Clinical Perspectives on multiple Personality Disorder* (pp. 277-300). Washington,DC: American Psychiatric Press.
Watkins, J.G. & Watkins, H.H. (1997). *Ego states: Theory and Therapy.* New York: W. W. Norton & Company.
Wieland, S. (2015). *Dissociation in Children and Adolescents Theory and Clinical Interventions* (2nd Ed.). London: Routledge.

Wieland, S. (2017). *Parents are our other Client – ideas for Therapists, Social Workers Support Workers, and Teachers.* New York/London: Routledge.

Yehuda, N. (2016). *Communicating Trauma: Clinical Presentations and Interventions with Traumatized Children.* New York: Routledge

Zovkic, I. B., & Sweatt, J. D. (2013). Epigenetic mechanisms in learned fear: implications for PTSD. *Neuropsychopharmacology*, 38(1), 77-93.

Used guidelines and practice parameters

AACAP (2005). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44, 1206-1219.

AACAP (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 414-430.

International Society for the Study of Trauma and Dissociation (ISSTD) (2003).Task Force on Children and Adolescents. Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents.

Drawing on the Evidence (Wolpert et al., 2000). PTSS, advice for mental health professionals working with children and adolescents.

NICE guideline (2005). Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care.

National Institute for Clinical Excellence in London Wolpert et al. (2006).

Strand, V., Sarmiento, T., Pasquale, L. (2005). Assessment and Screening Tools for Trauma in Children and Adolescents: a Review. *Trauma Violence Abuse*, Vol 6, 55-78

Zeanah, C., Chesher, T. & Boris N. (2016). Practice Parameter for the Assessment and Treatment of Children and Adolescents With Reactive Attachment Disorder and Disinhibited Social Engagement Disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 55 (*11), 990–1003