

TREATING COMPLEX TRAUMA in Children and Their Families

An Integrative Approach



Cheryl B. Lanktree • John N. Briere

Copyright ©2017 by SAGE Publications, Inc.

This work may not be reproduced or distributed in any form or by any means without express written permission of the publisher.



13

Cognitive and Emotional Processing

As noted at various points in this book, a significant amount of the distress experienced by children exposed to extended trauma consists of distorted cognitions and posttraumatic stress. In the former, the child's attempts to make sense of his or her early adverse experiences and the development of relational models based on inadequate or perpetrator-distorted information can result in negative attitudes, beliefs, and assumptions about self, others, relationships, and the future. The child may view himself or herself as inadequate, bad, unlovable, and helpless; others as emotionally unavailable, ill-intended, and inevitably more powerful than the child; relationships as dangerous; and the future as relatively hopeless (Dalglish, Meiser-Stedman, & Smith, 2005; Meyers, 2010).

Some of these assumptions are developed prior to the development of language, involving implicit, default perspectives that are not easily revisited or updated, and that are associated with negative emotions related to maltreatment experiences (Briere, 2002; Feiring, Cleland, & Simon, 2010). When activated, these relational schema may produce negative cognitive and emotional states, including terror, extreme fear of abandonment, sudden helplessness, or rage. These states may produce behavioral responses, such as unprovoked tantrums, screaming, crying, sexually reactive behavior, aggression, and other tension reduction behaviors (see Chapter 11).

Victimization also can produce posttraumatic stress, as described in the *Diagnostic and Statistical Manual*, 5th edition (DSM-5; American Psychiatric Association, 2013), although the criteria for PTSD are different for children under the age of 7. Posttraumatic stress often involves easily triggered sensory and experiential memories of trauma that present as flashbacks or nightmares, although not all children report sensory reexperiencing, and may instead relive trauma memories through posttraumatic play. There are typically attempts to avoid stimuli that would trigger such responses, such as avoidance of perpetrators, and seemingly phobic responses to school or home environments where maltreatment may have occurred. Finally, abused children may become hypervigilant, jumpy, and emotionally hyperreactive, or, alternatively, may be withdrawn, numbed, and dissociated. It is not uncommon for maltreated children to also display sleep disturbance, irritability, and attention and concentration problems (see the National Child Traumatic Stress Network [NCTSN] website at <http://www.nctsn.org> for detailed information on posttraumatic stress and other adverse effects of child maltreatment).

Most modern treatments for multiply traumatized children have developed specific interventions for these cognitive and traumatic stress-related difficulties. Typically, these involve some sort of (a) cognitive processing of trauma-related beliefs and expectations until they no longer interfere with daily functioning, and (b) therapeutic exposure to trauma memories, in safety, until associated emotions are desensitized or extinguished. Like these various other therapies, ITCT-C includes versions of cognitive processing and therapeutic exposure, although the implementation of these components is somewhat different.

Preconditions for Emotional Processing When Addressing Complex Trauma

The traumatized child may require a relatively stable home environment and a positive therapeutic relationship before he or she is able to revisit traumatic memories. Without this sense of safety and predictability, some children are too flooded with anxiety or hyperarousal to meaningfully engage in therapeutic exposure, or may need to use so much avoidance (e.g., dissociation, externalizing behaviors) to accommodate distress that meaningful processing of trauma memory cannot occur. As well, as noted in Chapter 11, to the extent that early trauma has blocked or limited the development of emotional regulation capacities, the child may need to learn internal methods of affect regulation before he or she can tolerate the trauma-related emotionality often triggered during treatment.

This problem is especially an issue for children who—as discussed in previous chapters—have experienced chronic neglect and repeated traumatization early in life, as well as additional traumas and (in some cases) social marginalization later in childhood. In such cases, the “trauma load” (i.e., the total amount of emotional distress associated with the cumulative impacts of trauma exposures and adverse social conditions) experienced by these children—in combination with their often insufficient emotional regulation capacities—means that they may be easily overwhelmed by interventions that require exposure to trauma memories too soon or too fast, or that occur without ensuring sufficient safety and protection (Briere & Lanktree, 2012; Ford & Courtois, 2013).

For this reason, ITCT-C stresses the need to assess both the complex trauma survivor’s amount of triggerable distress and his or her emotional regulation skills before a decision is made to provide significant therapeutic exposure. Further, like other relationally informed approaches, ITCT-C focuses on the development of a safe therapeutic relationship in which the client eventually may be willing and able to experience painful material.

This does not mean, however, that complex trauma survivors with high trauma loads and low affect regulation capacities do not receive any therapeutic exposure in ITCT-C. Rather, the amount of such exposure is titrated to the extent that the child can tolerate it, a constraint that may mean that some very traumatized children do not undergo much intentional emotional processing early in treatment. That is also why the ITCT-C approach involves flexibility in the chronology and timing of treatment components. In some cases, the therapist may need to return to interventions used earlier in therapy, for example, those focused on safety and attachment security within the therapeutic relationship, before additional trauma processing can occur.

Cognitive Processing

As compared to therapeutic exposure, cognitive processing is usually less activating, and thus less likely to overwhelm the client. For this reason, cognitive interventions usually occur earlier in ITCT-C, whereas emotional processing comes more into the fore later in treatment—generally as the child feels safer and more trusting in the therapeutic relationship, has a greater ability to express feelings, and, hopefully, has developed a more positive sense of self. However, cognitive therapy can also be intense, especially when discussion of the trauma triggers emotionally laden memories and, thereby, becomes therapeutic exposure. For this reason, ITCT-C uses an approach, *cognitive consideration* (Briere & Lanktree, 2012), that is also titrated to some extent—generally by allowing the client to have considerable say as to

what and how much distressing material is discussed or encountered. For example, even a child of 6 years can, with support, decide whether or not he or she is able to approach difficult experiences through play or art activities. He or she may say, “I don’t want to do any more,” “let’s play a game,” or “stop asking questions,” engage in an unrelated activity, or literally ignore the therapist. In contrast to approaches adhering more strictly to the therapist’s point of view, ITCT-C encourages the clinician to take such requests, statements, or behaviors seriously, and to view them as often legitimate attempts to titrate triggered emotional distress. At the same time, however, the reasons for the child’s avoidance should be investigated so that the underlying issue can be addressed.

Cognitive reconsideration accomplishes the reworking of trauma-related beliefs, assumptions, and expectations not by directly confronting the child’s “thinking errors,” or by labeling his or her cognitive distortions as irrational, but rather by providing a context in which he or she can reconsider previous assumptions or gain perspective on activated symbolic/implicit trauma memories during discussions or play. In general, it involves the client discussing traumatic events from the perspective of the past, while listening to the narrative in the present. This “coawareness” (Briere & Scott, 2014) of what the child thought then, and yet what he or she can understand now (i.e., given the passage of time, growing cognitive skills, absence of the perpetrator, and the presence of a safe and supportive therapist), allows the client to update his or her cognitions without substantial information from the therapist.

Ultimately, cognitive reconsideration is not a significant departure from classic cognitive approaches, except for its more permissive approach and reduced reliance on therapist feedback or interpretations. For example, a 7-year-old boy may insist, “I could have kicked his ass” (referring to the adult male perpetrator who sexually abused him when he was 5 years old). The therapist might then encourage the child to explore the original trauma scenario, what the child thought and assumed at the time, and what he or she thinks now—including how realistic the assumed solution (e.g., physical dominance of an adult) might be, in relative contrast to the therapist telling the client these things.

As with other components of ITCT-C, cognitive processing often includes multiple overlapping modalities:

- *Play*, which may be symbolic or direct reenactment, using age-appropriate toys and games such as animal and human puppets, sand tray (with a wide range of figures and objects to tell stories/enact scenes), dollhouse and doll families, and other tools in the play therapy room to reexperience the trauma from the original perspective and yet to also view or experience it in the present.

- *Classic therapy*, involving verbal processing of thoughts and memories that emerge during treatment, including discussions of the original logic of the client's initial understandings, and analyses (however simple) of how these abuse-specific cognitions can be updated or revised based on the child's current experiences or new information.
- *Expressive activities*, including use of drawings, art, collages, and games that allow expression of trauma-related thoughts and associated feelings from the child's current perspective.

These modalities allow the child to tell his or her story of the trauma(s) by enacting and/or verbalizing his or her experiences, after which he or she is more able to reconsider trauma-specific assumptions, beliefs, or expectations, and develop a relatively coherent and modern (updated) trauma narrative.

Reconsideration of Trauma-Specific Assumptions, Beliefs, and Expectations

As the child explores the traumatic event and related circumstances through verbal accounts, play, and expressive therapy, he or she has the opportunity to view the past trauma from the perspective of the present and come to whatever conclusions might logically follow. For example, Gil (2006) recommends slow and careful review of "what the child says to him/herself about what happened." The child may reconsider the basis or logic for what he or she considered previously to be "bad" behaviors, for example, the belief that he or she deserved the abuse because he or she came home late from school, lied, or challenged the abuser in some way, or "asked for" sexual abuse or exploitation by not resisting, or by seeking affection or attention. It may become apparent that a child believed that he or she should have been able to prevent or stop the abuse or the traumatic event, even though he or she had little control over the process and did not intentionally cause the event. In one case of nonabuse-related trauma, for example, an 8-year-old child believed that he caused his sister to be run over by a car while they ran to catch the school bus. Upon discussion of play-based reenactments, it became clear that he blamed himself for taking too much time to get ready, causing them to hurry after they left their house, and distracting his sister from watching traffic.

As these beliefs are acted out in play or through art, and then verbally explored in therapy, the child (with the assistance of the therapist) may be able to revisit the extent to which such assumptions "make sense" in light of the facts involved. Notably, this does not mean that the clinician points to cognitive distortions, *per se*, but rather supports the child's disclosure of

what he or she thought at the time of the event, and then invites the child to explore what he or she thinks about the trauma and his or her role in it now. Such exploration might be motivated by therapist questions like “Why was it your fault?” “Could you have fought him and not gotten hurt?” or “If that happened to your friend, what would you say to him/her?”, but rarely will it involve “talking the child out of” his or her beliefs or conclusions.

The child also may verbally express negative views of himself or herself that need to be explored. He or she may say, for example, “I am stupid,” “I look ugly,” or “No one will love me.” It can take time in therapy for a child to be able to share abuse- or neglect-related conclusions such as these. Yet, as he or she explores these views with a supportive therapist, the child can begin to consider the possibility that he or she is not “bad” and can be loved and cared for by others. This happens in two ways:

- By recounting and/or reenacting in play the original event(s) in enough detail, on enough occasions, that the original assumptions or interferences the child formed no longer seem reasonable in light of current conditions (i.e., in the context of safety, support for age-appropriate introspection, the absence of coercion, and a more developed capacity to think independently) and new information (based on what the child now knows about the rights of children, the wrongness of what was done to him or her, and, in some cases, gentle, nonintrusive psycho-education from the therapist regarding these issues).
- By experiencing a relationship with the therapist that contradicts the lessons of past relational trauma, for example,
 - that one can be vulnerable without being hurt or exploited;
 - that powerful people are not always mean, dangerous, or emotionally unavailable;
 - that not everyone who matters sees the child in a negative light;
 - that he or she is lovable and intrinsically valuable; and
 - that he or she has entitlements as a child, as well as a human being, that cannot be abrogated just because someone else might wish to do so.

Most basically, the child ideally learns from a positive therapeutic relationship that the conclusions he or she formed in relationship to abusive, exploitive, or neglectful others do not have to be generalized elsewhere—as witness his or her current experience.

To the extent possible, it is important that the child comes to these various realizations by himself or herself, as opposed to merely being told by the therapist. Of course, there is nothing wrong with the therapist telling the child

that the trauma wasn't his or her fault, that he or she is a good person, or that he or she is safe with the therapist—these are good points to make, so that the client will at least hear the therapist take a stand that is the opposite of the client's perpetrators or deleterious aspects of the social system. However, such statements, by themselves, rarely change cognitions in an enduring way. Instead, the goal is for the child client to have the opportunity to come to the conclusion, on many occasions, that given current data, current experiences, a more sophisticated neurocognitive capacity, and a perspective now less limited by fear and coercion, the initial assumptions he or she made in response to trauma are invalid or incomplete. These lessons are rarely successful if the child merely hears about what is true; he or she generally has to experience it—both in a supportive, caring, engaged relationship, and based on his or her own investigations and reflections during trauma processing.

Development of a Life/Trauma Narrative

Many traumatized children require some time in therapy (the extent of which will vary from child to child) before they can develop a coherent and meaningful narrative about their life and the role of trauma in it. Typically, the life/trauma narrative will unfold over time as a partial function of the child's sense of safety, outside and inside the session, and trust in the therapist.

A common ITCT-C intervention is for the child to create a "timeline" or map on a large piece of paper, marked with different ages, where he or she lived at various points of time, who lived with him or her, and so on, and then to add in words or drawings what happened to him or her at each major time point, including both positive and traumatic experiences. This, then, becomes a visual representation of significant events in the child's life up to the current time. A child may also want to record his or her "story," or trauma narrative, as if telling another child in similar circumstances who is having problems disclosing or talking about his or her abuse.

An older child may wish to journal about his or her experiences, in writing and/or drawings, then share with the therapist what he or she has written or drawn. If the child does not feel that the journal can be safe at home (e.g., without others reading it, or it being stolen or destroyed), the therapist can store it in his or her office, and the child can take it out, read it, and make additions during therapy sessions. One child who found journaling helpful also spontaneously drew illustrations to accompany her writing—a drawing titled "Liar, liar, pants on fire," showing her stepfather who had sexually abused her with his pants on fire—then wrote a few pages about how he had helped her with homework, would take her on outings and give her special

attention, then abuse her. Because she did not feel supported at home, this client kept her writing and drawings in a folder locked in a drawer in the therapist's office. She was eventually able to explore more fully her verbal narrative in therapy, interspersed with more writing, eventually compiling several illustrated chapters describing her traumatic experiences.

Many severely traumatized children need a significant number of sessions in order to cognitively process their various trauma exposures. In addition, as previously stated, it is frequently the case that they will need to return to other components of ITCT-C, such as further affect regulation training, safety, exploration, and development of a more positive identity, and more attention to attachment issues in the therapeutic relationship before they can fully address the most relevant memories. More aspects of the narrative may be disclosed later in therapy, when the child client experiences a greater sense of trust and self-efficacy, and feels less likely to be overwhelmed by the material.

In one instance, a child who had experienced many different types of traumas, including abandonment by a parent, sexual and physical abuse, and multiple placements, was eventually able to describe several attempts on her life by one of her mother's boyfriends, including an attempted drowning in the bathtub and holding a knife to her throat—but only once she had explored and processed other traumatic experiences was she able to feel safe in therapy sessions, and more secure in her adoptive family's home. In fact, this child eventually disclosed more about these life-threatening experiences while in family therapy sessions with her adoptive parents—but only after a number of months of individual therapy, simultaneously with individual and conjoint collateral sessions. It is a common experience of therapists working with complex trauma that some of the most threatening and frightening experiences children have experienced may only be disclosed and explored later in therapy, when successful trauma work has reduced traumatic stress, the therapeutic relationship has developed sufficiently, and safety has been repeatedly established.

Emotional Processing

Emotional processing of trauma memories usually involves some form of exposure therapy. Although there are many definitions of therapeutic exposure, it can be defined as any activity that intentionally triggers trauma memories in the context of therapeutic safety. Once triggered, these memories may activate additional emotional responses/memories (e.g., fear, anger) that were initially linked to the trauma memory. As these emotions

are repeatedly elicited, but not reinforced (because there is an absence of danger or trauma in the session), and potentially counterconditioned by the positive feelings associated with the therapeutic relationship, the emotional connection to the trauma memory weakens, until it is eventually extinguished and the memory loses its ability to produce distress (Briere & Lanktree, 2012; Briere & Scott, 2014).

Notably, however, we recommend *titrated* exposure (Briere, 2002) when working with children exposed to trauma. Titration in this case means that the memories are carefully activated so that they do not exceed the child's affect regulation capacities. In other words, whereas classic exposure may engender potentially overwhelming emotions, titrated exposure usually involves lower levels of emotionality; the process is often less intense, and slower, because the clinician strives to ensure that the child's emotional responses are not unduly frightening or distressing to the point that the trauma exposure retraumatizes or compromises the child's perceived safety. Fortunately, the use of play and expressive interventions in ITCT-C usually means that the child remembers in a safer, more structured context in which memories are accessed in smaller, less challenging increments.

Specific Interventions for Emotional Processing

As is true for cognitive therapy, exposure therapy with children may involve multiple modalities: *play therapy*, using puppets, dolls, sand tray, and the dollhouse and doll families for younger children; *psychotherapy*, which may include the use of board games, projective card games, and verbal processing; and *expressive therapy* through art, drawings, and collages. All modalities involve titrated exposure to upsetting memories.

When expressive/art therapy is used, children may make a drawing or collage or write a poem of how they felt before they were abused or experienced another type of trauma, as compared to how they felt afterwards. Exposure in this case probably involves two related processes: exposure to memory that is required by drawing or writing about their responses to the trauma, and exposure to the experience of hurt and loss evoked by comparing the two depictions. At the same time, the positive feelings associated with play or artistic expression may countercondition these emotions, as well as serving as a way that the child can dilute full access to painful memory by presenting it in symbolic form.

Children may draw a self-portrait of a time when they were hurt, or in some other way make a drawing that facilitates the expression and processing of trauma-related feelings. For example, a child whose parents had been shot and killed by an intruder in their home drew a picture of his parents being shot and himself hiding in another room. It was only after expressing

his experience in this way that he was able to begin to explore and process trauma-related feelings in a direct and more verbal manner.

Other options may include kinetic family drawings (i.e., of the family doing something) or a “snapshot” of their family (see Chapter 16), both of which can elicit memories and feelings that the child has for different members of his or her family. This focus may be especially helpful when the maltreatment occurred in the context of the family, the trauma affected the family in some way or another, or the family’s response (lack of support, denial, blame) was an additional source of trauma.

Children may also want to bring to sessions photo albums, pictures, or videos of themselves at different ages, as well as those of family members. Pictures are often quite evocative in terms of triggering traumatic (and non-traumatic) memories, and thus may be effectively used as a form of therapeutic exposure. They also may activate additional, more remote or avoided memories, which may then be processed as well.

In order for emotional processing to be maximally helpful, the child must have sufficient development of expressive language skills regarding his or her internal states. The child should be able to label feelings, a process that can be facilitated by feeling charts, books, drawings, games, and so forth, as described in Chapter 6. In some cases, the child may need more encouragement and specific activities in order to sufficiently communicate feelings and thereby process them. These may include physical activity, role-playing, play therapy (e.g., enacting scenes with the sand tray, dollhouse, or puppets), drawings, collages, and other art therapy activities.

An intervention that children have found especially helpful for emotional (and cognitive) processing of traumatic experiences is the “hat game” (see Chapter 17), which can be used in individual and group therapy sessions. In this activity, the child and therapist write down questions on pieces of paper that relate to the traumatic experience(s) and related feelings. Examples of questions might be, “How were you hurt?” “How many times were you abused/hurt/witnessed someone else getting hurt?” “Who abused/hurt you?” “Did you tell anyone what happened?”—all written in language appropriate to the developmental functioning of the child and his or her specific experiences. The questions are then put into a hat or other container, and the child pulls a question from the hat, and then responds in whatever way he or she can to express feelings and thoughts related to the trauma. Exposure occurs when the child (with the therapist) writes down the questions, and again when he or she answers them. In this way, the child is provided some structure for processing emotions, including support to pace him- or herself regarding how much he or she is able to express to the therapist. If a child is unable, or does not wish, to answer a question, he or she is encouraged to express his or her feelings and why it is difficult.

Another technique involves clients writing onto pieces of paper all the “disgusting” things that they can think of (e.g., “dog poop,” “vomit,” “snot”) along with the things that happened to them that were upsetting. Everything goes into a “garbage bag” and is stored in the therapist’s office (James, 1989). By accustoming the child to descriptions of negative, unwanted, abhorrent things, this exercise can facilitate his or her discussion of trauma experiences that have been experienced as shameful or too “bad” to verbalize in the therapy session. If this exercise is used, however, it is important that the child understand that it is the abuser’s behavior that is repugnant, not in any way the child’s or his or her own responses.

Older child clients also may find it helpful to write (or dictate) a letter that is directed to the perpetrator or the person they have identified as hurting them or not protecting them. Although not required in trauma therapy with children, letter writing—if the child is in favor of it and does not feel pressured to do it—can be a good exposure activity; the trauma memories are activated by writing about the abuse and by the fact that the letter is written to the abuser. It further allows for the expression of abuse-related emotional states, which, in the presence of therapeutic safety, can be further processed. Finally, there may be cognitive benefits as the child expresses the unfairness, cruelty, or inappropriateness of the perpetrator’s behavior, or the traumatic loss of a loved one, thereby exposing himself or herself to these statements. It is important to note that these letters are never sent to the actual individual; their function is only to promote emotional and cognitive processing. A child who is feeling supported by another family member (e.g., caretaker) may also want to share the letter with him or her. In the case of a letter written to the abuser, it is often a good idea to visibly destroy the letter with the child’s permission, so that he or she can feel safe later on that the abuser was never actually aware of what the child wrote.

Although letter writing is often focused on the abuser or nonsupportive parent, this activity is sometimes also used to support the child’s experience of grief. In such cases, the letter is written to someone close to the child who has died (e.g., beloved parent or grandparent), has been incarcerated, or in some other way is not available to the child. The content of such letters often involves saying good-bye, conveying sadness, or describing feelings (including anger) associated with abandonment.

Continued Use of Other ITCT-C Components During Emotional Processing

As the therapist facilitates emotional processing of trauma, it is also important to continue to evaluate attachment/relational issues, affect regulation capacity, and safety/trust in the therapeutic relationship, especially if

the child is struggling with the expression of upsetting feelings. Of these, safety may be the most pressing issue. Because exposure is just one part of the therapy process, it is quite important that the clinician express, demonstrate, and reinforce the safety of the therapeutic environment, including his or her own nondangerousness and willingness to protect the child. In other words, although the client is exposed to the trauma memory through play or discussion, and the memory activates associated emotional states (e.g., distress), there has to be a disparity between the activated emotional state and the current therapeutic environment, so that the emotions, unreinforced, will extinguish (Briere, 2002). Exposure without safety is quite unlikely to provide emotional processing—in fact, it may reinforce the client's triggered emotional states. For this reason, the various safety-oriented activities outlined in previous chapters must be in place if the interventions described here are to be helpful.

Finally, safety and support extend beyond the therapy session. A safe and, ideally, supportive home environment can contribute greatly to a child's ability to process his or her emotions in treatment. For example, a 7-year-old boy ("Jaime"), who expressed particularly strong feelings of anger toward the man who had sexually abused him, was able to process his feelings more directly and explicitly in sessions when supportive family members were also in the therapy room. As described in Chapter 11, Jaime's play involved a physical expression of his feelings with a game he created that involved a target drawn with concentric circles (like a dart board) representing body parts of the perpetrator. The target was attached to a wall in the therapy office, and Jaime, his family members, and the therapist took turns throwing a soft ball at it, winning points with each turn. During the course of the game, they expressed their feelings explicitly while also engaging in a game that was fun for them. The primary focus of this exercise was for Jaime to express anger in a less threatening game context, but also to experience a sense of self-efficacy and empowerment, while being supported by his family and the therapist in doing so. This game also facilitated further processing of Jaime's trauma in individual and family therapy.

Addressing Avoidance and Dissociation: Feedback From the System

As noted in Chapter 2, dissociation and other forms of avoidance are often used by the traumatized child in order to reduce his or her direct experience of trauma-related distress. This may be especially true if he or she has experienced multiple traumatic exposures and has not had the benefits of a secure relationship with a primary caretaker. Although such responses can be adaptive on some occasions, when they intermittently occur in therapy

they may signal that the client is overwhelmed by activated trauma material. Further, as noted earlier, significant dissociation, by definition, means that the client is disengaging from activated emotional distress, and thus is reducing the extent to which trauma exposure and processing can occur. Ultimately, it may indicate that he or she is not feeling safe in treatment.

For these reasons, the therapist should keep track of whether the child is dissociating during treatment, for example is appearing “spacey,” seems more detached or disengaged, or engages in verbalizations or behaviors that are not typical for him or her. A child might not be aware of what was just asked by the therapist, or may suddenly act aggressively (e.g., throwing a toy) then appear to have no knowledge of what just occurred. When apparently overwhelmed by trauma-related memories and feelings, a 6-year-old girl (“Solyna”) who had been severely traumatized frequently adopted a regressed voice in therapy sessions while crawling on the floor and saying “I’m Baby,” or, alternatively, shouting in a low voice and making angry faces, saying, “Now, I’m Joe.” Fortunately, with considerable therapy, Solyna was eventually able to describe the feelings represented by her assumption of these roles or identities, and could process them more directly and effectively in the “here and now.”

When dissociation is present for significant periods in the session, the first task is often for the therapist to explore with the client possible sources of danger or threat outside of therapy, including the possibility of current abuse or neglect at home or elsewhere. It is possible that a child who appears to be in a safe home environment is, in fact, being threatened or abused by the very person who is bringing him or her to therapy. For example, a previously abusive family member who left the home may have returned. The first author has worked with children who were experiencing abuse or neglect, either on “monitored” visits or in their primary home environment, which then contributed to anxiety and dissociation in therapy sessions when they were reminded of trauma-related material. Not all dissociation may arise from dangers within the family, of course; the child may be dissociated due to being harassed, threatened, or victimized by peers, gang members, or other adults in his or her environment.

If external reasons for increased dissociation can be ruled out, or if dissociation notably occurs at certain points in treatment, it is possible that the therapy itself or therapy stimuli are producing the response or motivating the client’s avoidance. In “Self-Trauma” terminology (Briere, 2002; Briere & Scott, 2014), it is possible that the therapist is “overshooting the therapeutic window,” that is, exposing the child (or allowing the child to expose himself or herself) to too much trauma material relative to his or her existing emotional regulation skills. If so, it is a good idea for the clinician to reevaluate his or her opinion of the child’s overall trauma load and affect regulation capacities. The therapist may choose to reduce direct exposure activities, to

some extent, perhaps instead providing options for the child to engage in activities that provide more indirect and/or less intense emotional processing, such as drawings, games, or sand-tray work. Most basically, the clinician must evaluate how successfully he or she is, in fact, titrating the client's exposure. Even if nonverbal modalities are not indicated at the moment, the therapist may need to proceed more slowly, focus less on the details of the trauma, move strategically into less evocative activities, such as cognitive reconsideration or temporary discussions of less trauma-related things, or otherwise reduce the intensity of the client's emotional activation. For children whose ongoing distress and traumatization is a major issue, and the therapeutic window is likely to be exceeded, it may be helpful to have a neutral play period at the beginning of the therapy session, so that he or she has an opportunity to gradually enter trauma processing at his or her own speed. Finally, it may be that the child needs more attention to the further development of emotion regulation skills, as outlined in Chapter 11.

An Exposure Philosophy

The reader will note that the exposure activities outlined in this chapter are characterized by a significant level of permissiveness on the part of the clinician. He or she rarely takes the child through preconceived exposure hierarchies, but spends considerable time ensuring that the client is not overwhelmed by the process. In fact, ITCT-C clinicians generally encourage the client to determine what and how much traumatic material should be addressed in any given session. For example, the therapist often provides a number of options for the child client, including books, toys, art materials, and so forth, while encouraging the child to explore trauma-related material in a gradual, titrated fashion.

In addition, the child is encouraged to explore multiple traumatic experiences in a given session, if desired, as opposed to just focusing on a single one, as is suggested in some other treatment models. For example, the child might begin the session acting out an incest experience during sand-tray work, and then suddenly describe or enact in play a trauma at the hands of another adult or a peer. He or she might then return to the incest memory, or engage in an elaborate game involving some other topic or memory. In general, ITCT-C suggests that the clinician follow the client's lead, facilitating emotional and cognitive processing whenever it seems relevant to the child's disclosures or play behavior, while at the same time allowing the child to deescalate processing when he or she feels overwhelmed or overstimulated.

For example, an 8-year-old girl, "Abida," reenacted repeatedly in therapy sessions, week after week, a scene in sand-tray play depicting abuse and

abandonment by “monster” figures. Abida was eventually encouraged by the therapist, after a number of sessions, to explore a more positive outcome for the scenario, rather than repeated abuse of the little girl and boy figures with a lack of intervention by the “safe” people figures. Abida responded with rage, shouting, “No, nobody helps!”, appearing to be triggered by the suggestion that others might help the abused children. In response, the therapist engaged Abida in a gentle discussion about why she thought, “Nobody helps,” keeping the conversation as general as necessary to not overexpose her to activated abandonment memories. The therapist also used grounding interventions to help Abida feel less distress, and then invited her to play a favorite game that was not obviously connected to her abuse. Abida continued in subsequent sessions to use sand-tray play, reenacting the same scene, albeit with more emotional processing. However, the clinician implemented multiple breaks from sand-tray work in each session, inviting Abida to practice mindful breathing and other grounding activities when she felt she was in danger of exceeding the therapeutic window. After a number of sessions conducted in this fashion, Abida eventually discovered her own positive resolution, which was for the frightening, abusive “monster” figures to be replaced by a loving bunny family who rescued the little boy and girl.

Importantly, it may be helpful for the clinician to not necessarily assume that “resistance” or “oppositonality” is present for a child who, in contrast to Abida, appears to be avoiding certain exposure activities or conversations. In fact, another hypothesis may be more germane: the therapist may be making a “process error” (Briere & Scott, 2014), for example, by pushing the child too hard or focusing on emotional processing activities when emotional regulation, relational work, or safety interventions would be more helpful. This does not mean that the therapist does not encourage the child to engage in exposure activities to the extent they are indicated and can be tolerated, however. In fact, in some instances, especially with younger, more consistently avoidant children who appear able to process more than they currently are, the therapist may need to be more directive in gently encouraging increased trauma processing.

The issue, therefore, is not whether therapeutic exposure is helpful; it usually is. Rather, the primary notion is safety: Can the child remember without being overwhelmed? Can the session ground and support as well as facilitate emotional processing? When in doubt, the old medical dictum for treating vulnerable patients with powerful medications may be in order: “start low, and go slow”; don’t forgo exposure, but rather titrate it to the client’s existing challenges and capacities, so that therapeutic work occurs and the client is not overwhelmed. In some cases, this may even mean that emotional processing takes a backseat to other intervention components, at least until the client is more able to tolerate activated, trauma-related states.