Perception is Reality: Helping Systems View Childhood Dissociation Through a Complex Lens

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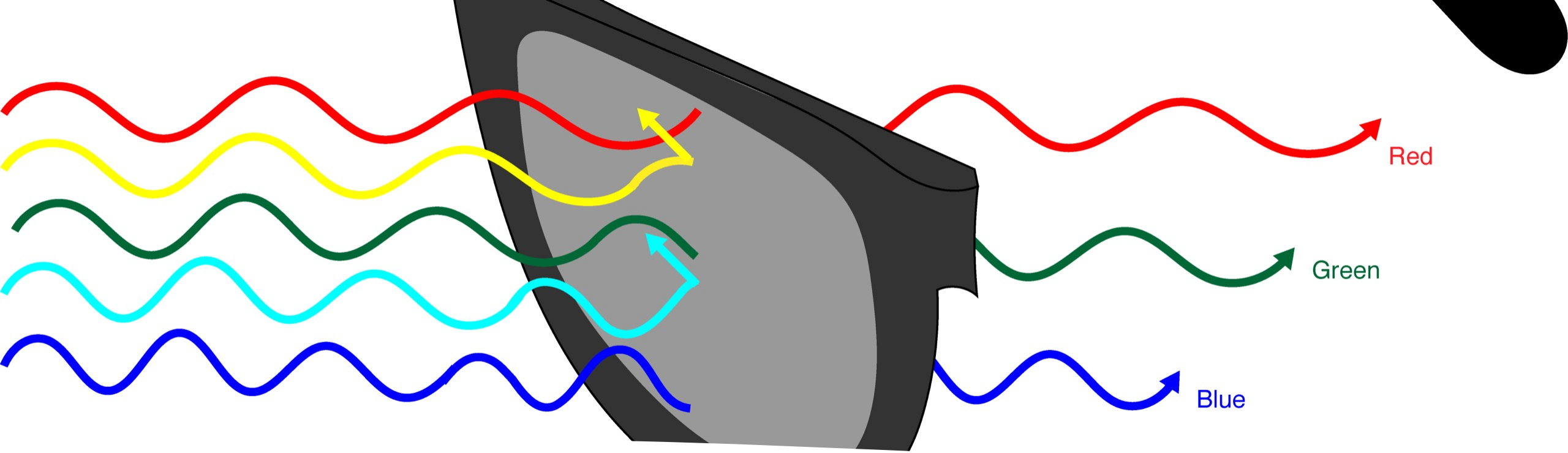


Learning Objectives

1. Identify dynamics related to dissociative blindness that are often encountered in the systems that interact with young clients with complex trauma
2. Discuss case examples of dissociative children that are prototypical of generating systemic stigmatization
3. Describe strategies to gain the cooperation of disbelieving, sometimes punitive professionals to understand and accept dissociative diagnoses for youth.
4. Describe integrative intervention strategies with professionals in various systems that shift from a lens of fear and punishment to a lens of empathy, understanding and effective treatment for youth with complex trauma and dissociation.
5. Describe treatment techniques for complex youth with identified comorbidity

- Education
- Residential
  - Mental Health
  - Substance Abuse
- Child Welfare
- Juvenile Justice
- Mental Health
- Pediatric Health
- Others?

Child Serving Systems

Systems and Dissociative Blindness

Shhh! Don’t say the “D” word to the jury

- They won’t understand
- It will discredit you
- “Normal” people won’t get it
- Prevailing Myths must be addressed
- Systems (including courts) must be educated
- Missing link is often dissociation

Educate!

- Myths
- Brain Science
- Complex Trauma and Dissociation
- Attachment
- Importance of Physical and Psychological Safety

Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder

1. Belief that DID is a fad
2. Belief that DID is primarily diagnosed in North America by DID experts who overdiagnose the disorder
3. Belief that DID is rare
4. Belief that DID is an iatrogenic, rather than trauma-based, disorder
5. Belief that DID is the same entity as borderline personality disorder
6. Belief that DID treatment is harmful to patients.

[Brand, BL., Sar, V., Stavropoulos, P., Krüger, C., Korzekwa, M., Martínez-Taboas, A., & Middleton, W. (2016)]

Brain Science

- Mounting evidence from neuroimaging studies that Dissociative Identity Disorder is a severe form of PTSD originating from severe and chronic (childhood) traumatization.
- Imaging studies continue to reinforce brain differences such as smaller volume in the hippocampus in persons with severe dissociation as well as in persons with high Adverse Childhood Experiences (ACEs).
- Dissociation is a brain adaptation that developed to aid the survival of the person.

Reinders, S, Marquand, AF, Schlumpf, YR, Chalavi, S, Vissia, EM, Nijenhuis, ERS, Dazzan, P., Jancke, L, & Veltman, DJ (2018). Br J Psychiatry Dec 2018; Teicher 2012, Teicher et al., 2016; Chalavi et al, 2015

Brain Science

- Exciting strides in neurobiology show that dissociation is accompanied by altered activation of brain structures…involved in regulating awareness of bodily states, arousal, and emotions.
- Neuroimaging studies provide concrete, theoretically consistent evidence that dissociation exists and cannot be simulated.
- Functional Neuroimaging shows that trauma survivors with more dissociative symptoms have a pattern of hyperfrontality and limbic inhibition that was the opposite of that seen among those with the more common hyperarousal type of PTSD, who had limbic hyperactivation and hypofrontality.

Bethany Brand, (2012); David Spiegel, (2018); Vesuna et al., (2020)

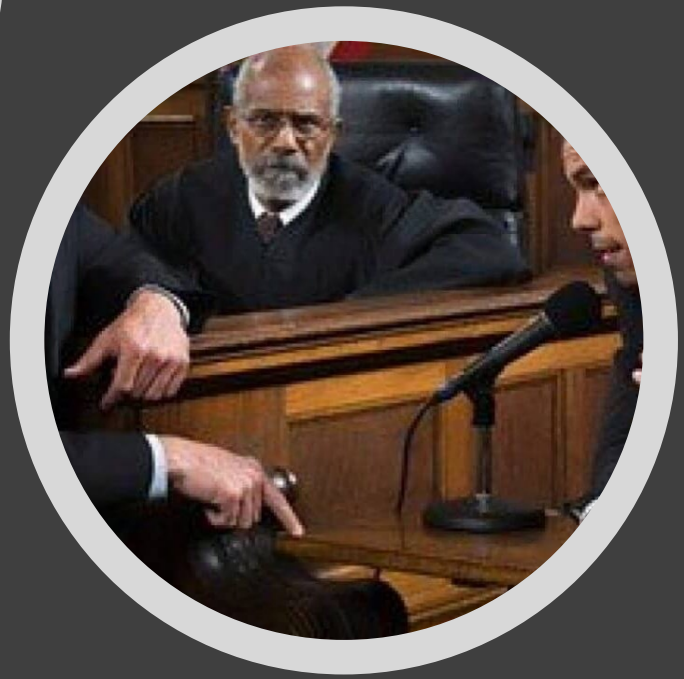
Reinders et al., 2012, 2018, Hopper et al., 2007; Lanius et al., 2010, 2012, Chalavi et al., 2015

Brain Science

- Advanced imaging methods identified the molecular, cellular, & physiological properties of a deep posteromedial cortical rhythm that underlies states of dissociation caused by trauma, epilepsy, or dissociative drug use.
- Impressive recent studies of brain biomarkers such as differences in grey and white matter patterns can differentiate persons with DID from healthy non-DID persons *at the individual level* .

Bethany Brand, (2012); David Spiegel, (2018); Vesuna et al., (2020)
Reinders et al., 2012, 2018, Hopper et al., 2007; Lanius et al., 2010, 2012, Chalavi et al., 2015


Systems and Dissociative Blindness:
Case Example



Court: Connecting the Dots

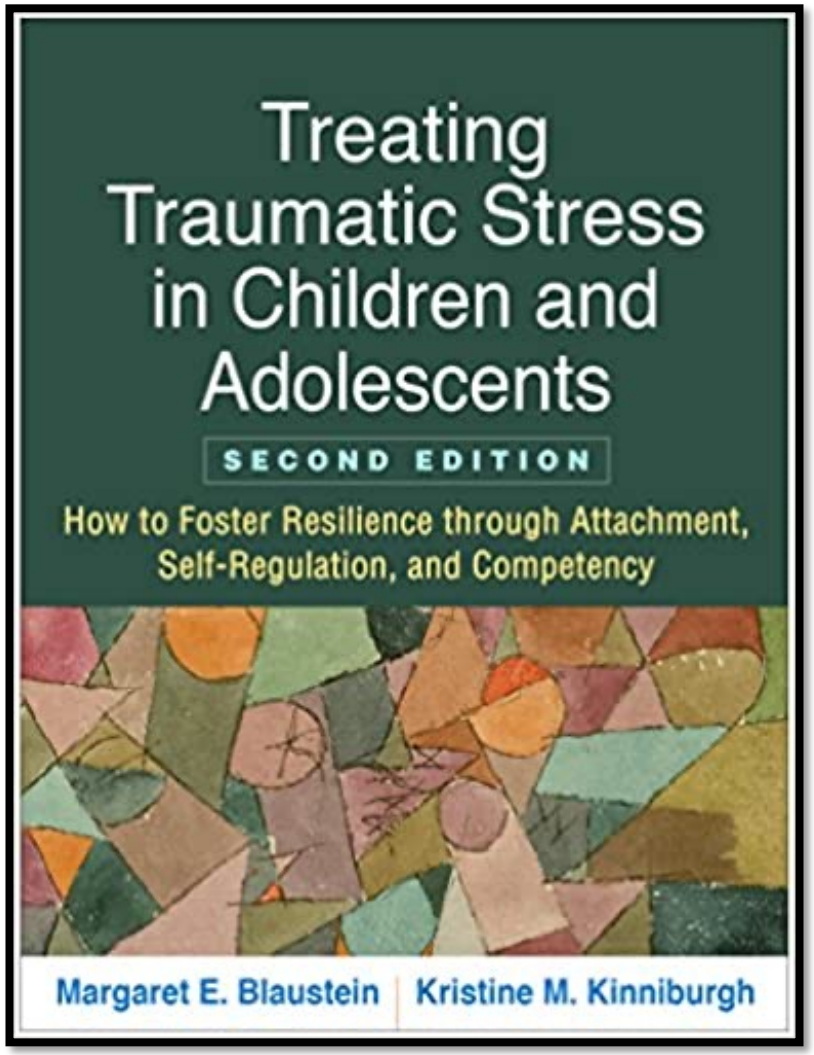
We need Integrative intervention strategies across systems that shift from a lens of fear and punishment to a lens of empathy, understanding and effective treatment for youth with complex trauma and dissociation.

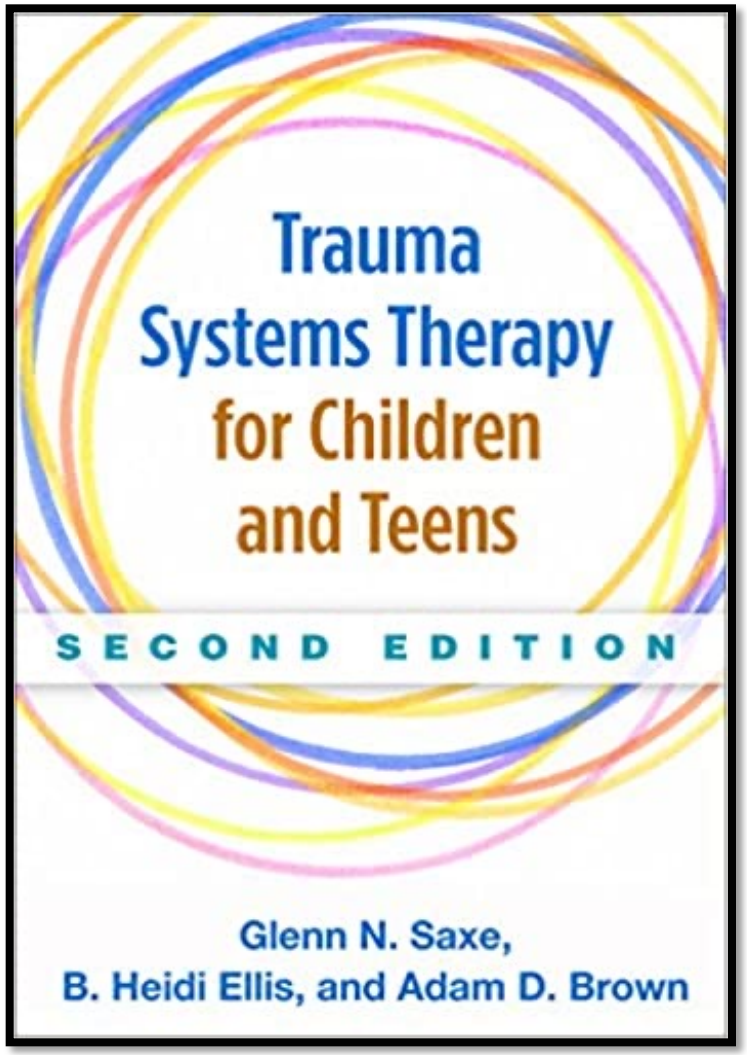
Intervention Strategies Across Systems "Attachment Based" Approach for Dissociation

- Educational System
- Residential Systems
  - Treatment Centers
  - Substance Abuse Recovery Centers
- Child Welfare System
- Juvenile Justice System
- Mental Health
- Pediatric Health

- Belief that the child can get well
- Uniform dissociative treatment approach
- **Uniform felt safety and trust**
- **Identify a key treatment person**
- **Identify peer support person**
- Family involvement
- Ongoing team collaboration
- Consultant on dissociation
- Formal & informal training

Trauma Models that Address the Broader System



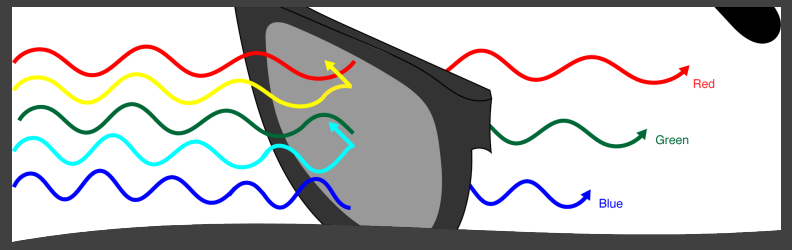


How to gain cooperation of skeptics of dissociation?

Educate!

- Core Symptoms of Complex Trauma and Dissociation
- Misdiagnoses/Misattributions

Perception is not always Reality



Behaviors seen as …

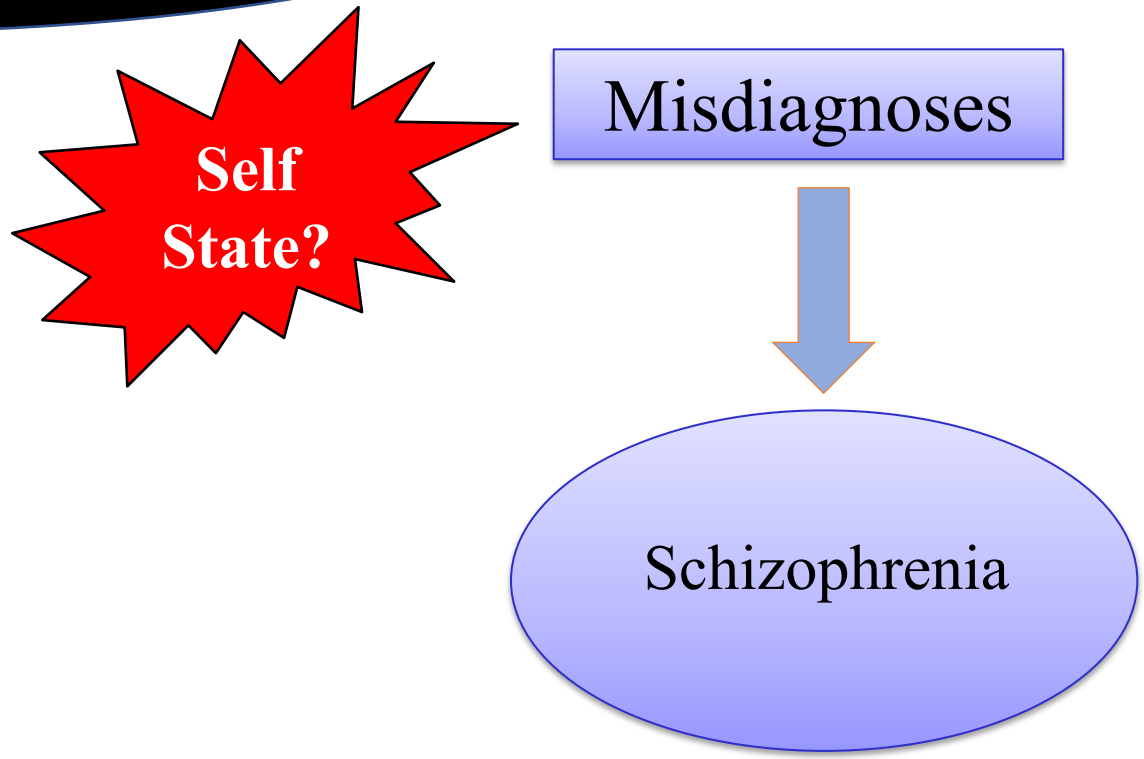
1. Learning Disabilities
2. Aggressive/Delinquent/Bad
3. Overly Controlling
4. Regressive (e.g., encopresis)
5. Sexual/flirtatious
6. Clingy; fearful
7. Ambivalent – wants help but rejects it
8. Psychosis/hallucinations
9. Attention seeking through self harm

May actually be…

1. Dissociation
2. A Protector self state
3. Distrust- meets own needs
4. A younger self-state
5. A sexually abused self state
6. Complexly traumatized; an abandoned self state
7. A child with disorganized attachment
8. Dissociative hallucinations
9. Suicidal or self harming self state

Auditory & Visual Hallucinations

- Voices no one else hears
- Visions of others no one else sees



Identity Confusion

Self State?

Misdiagnoses

Schizophrenia

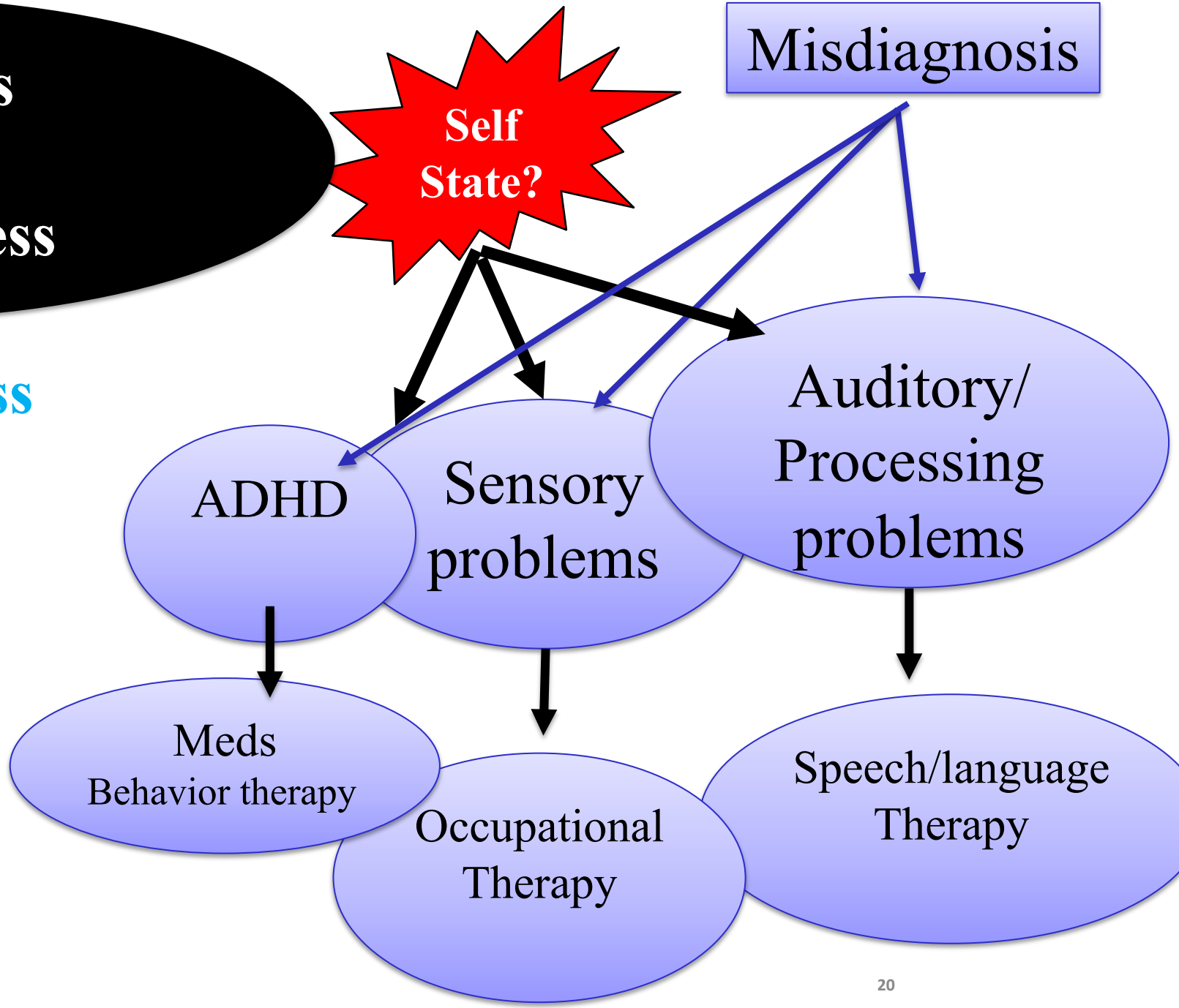
Autism Spectrum

Disorganized

Chaotic

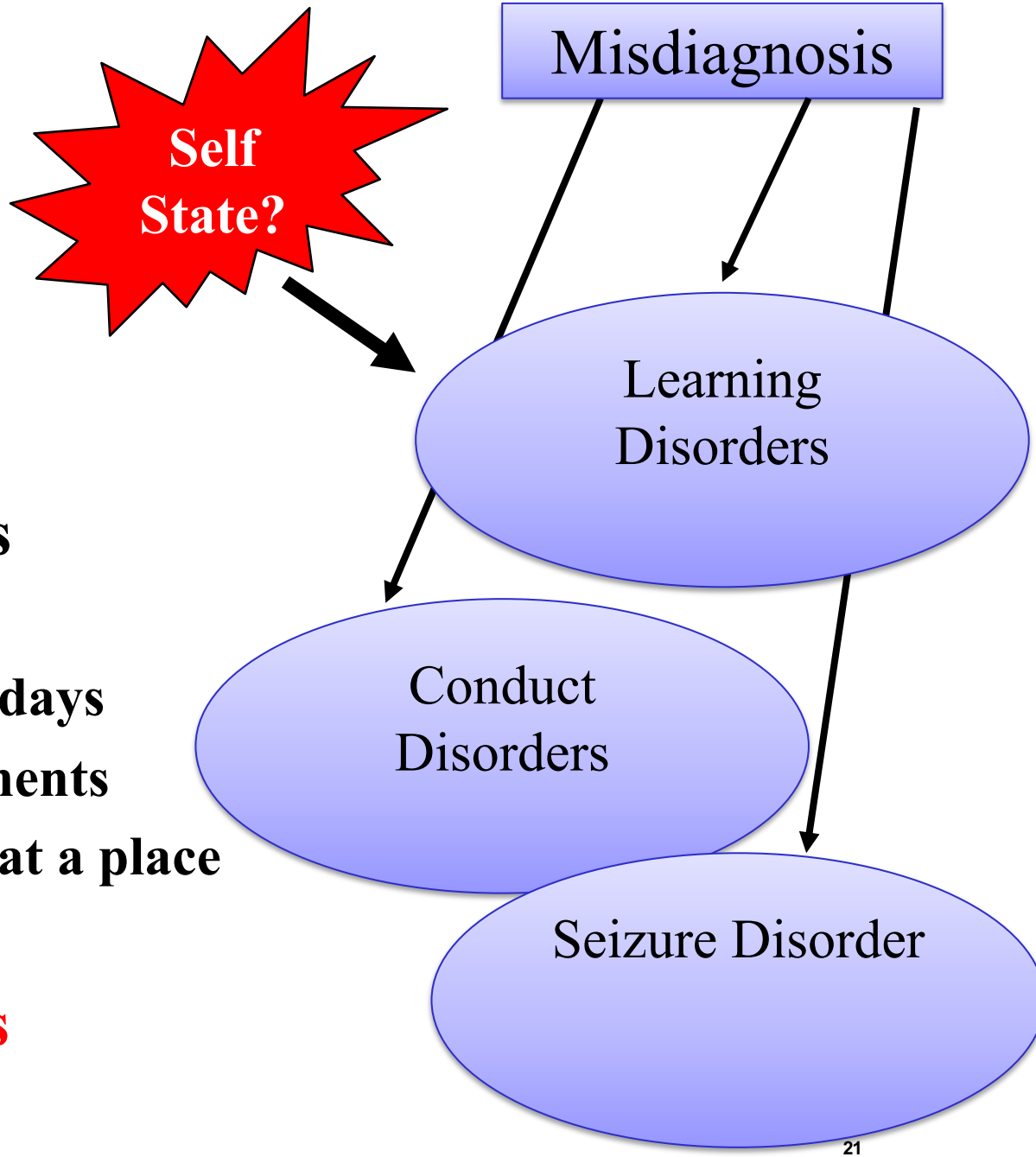
- **Disturbances in identity**
  - **Hallucinations**
  - **Parents & teachers may view**
    - **Child behaving very differently- “odd”**
    - **Disconnected/detached-poor eye contact**
    - **In own world, non-communicative**
    - **Highly sensitive, explosive**
    - **Repetitive behavior**
    - **Lack awareness of change in self or surroundings & caretakers**

Alterations in Consciousness



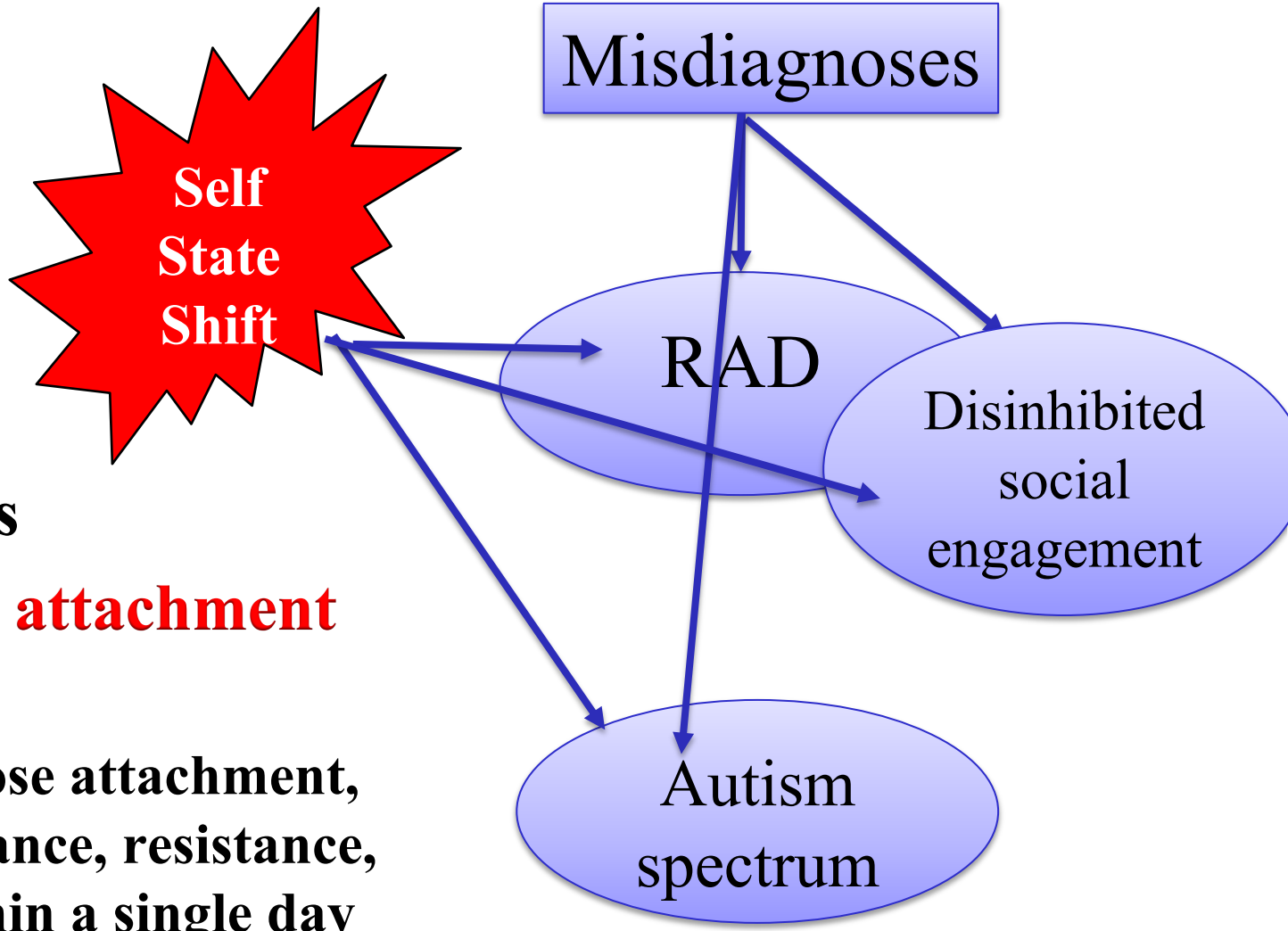
- **Distortions in awareness**
  - **Seeing but not hearing**
  - **Staring off**
  - **Visual distortions**
    - Tunnel vision
    - Seeing from a distance
  - **Not in control of body**

Memory Disturbances



- **Memory Problems/Amnesia**
  - **May be past and present events**
    - **Traumatic & non-traumatic**
    - **Significant events-birthdays, holidays**
    - **Past teachers, homework assignments**
    - **Doesn't recall how h/she arrived at a place**
    - **Aggressive acts**
  - **Disavowed witnessed behaviors**
    - **Called liars**

Extreme Mood & Behavior switches



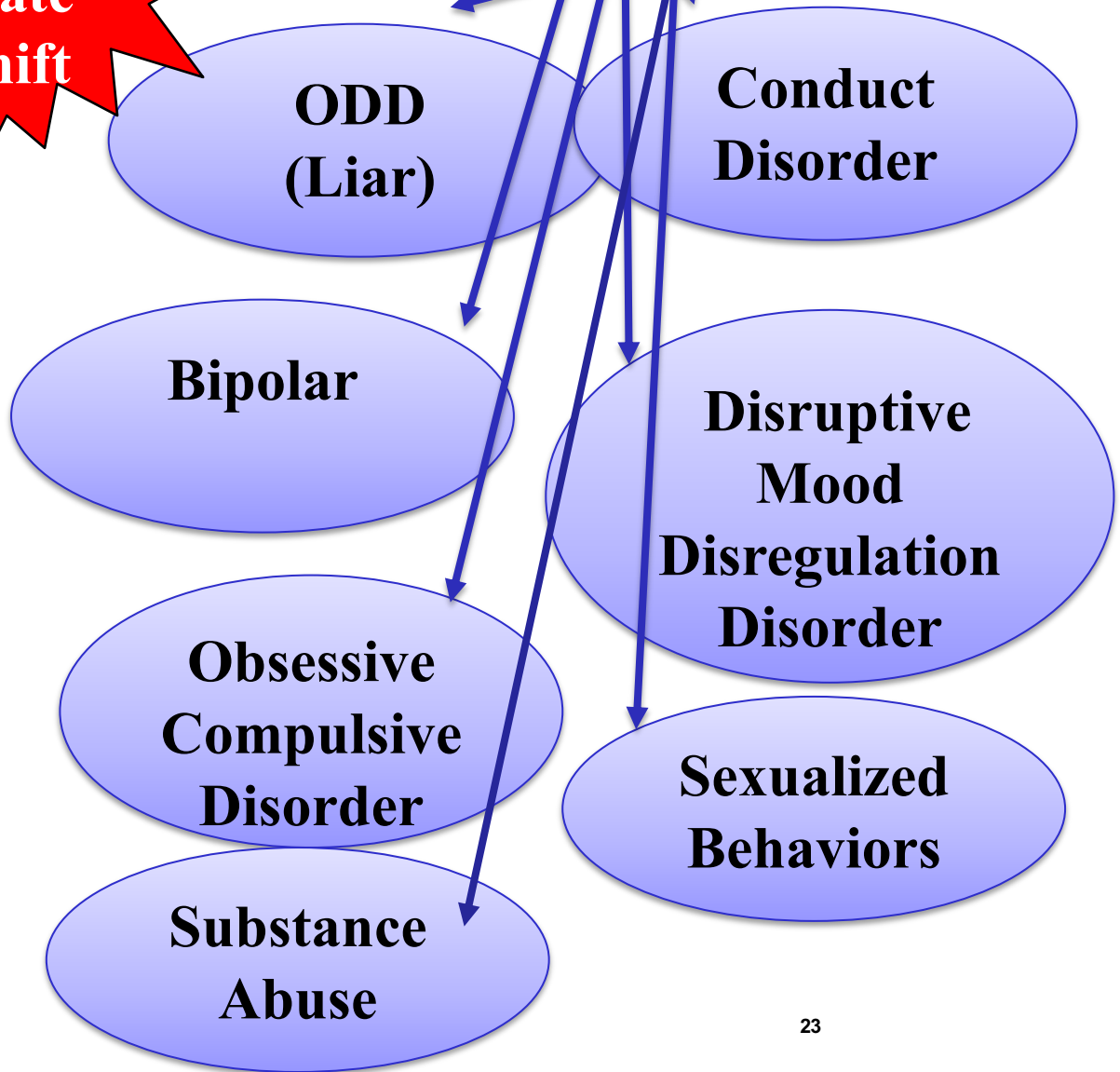
- **Impairs attachment process**
- **Children show inconsistent attachment behaviors**
  - **Vacillate rapidly between close attachment, complete detachment, avoidance, resistance, and hostility to a parent within a single day**
  - **State changes**

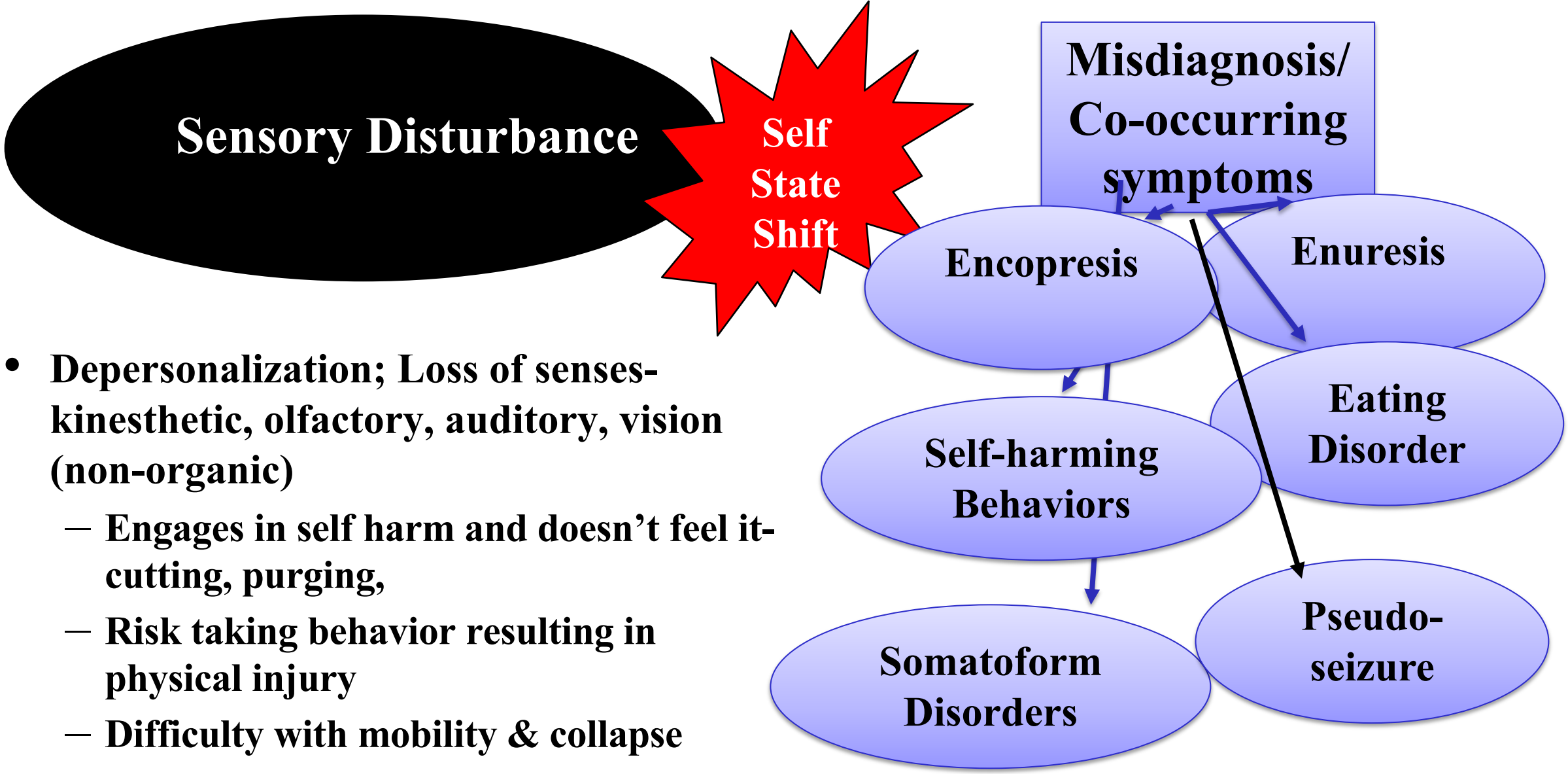
Extreme Mood & Behavior

Self State Shift

Misdiagnoses/ Co-occurring symptoms

- State shifts ➡ dysregulated affect & behavior
  - Amnesia
  - Observer is stupefied as to what happened
  - Disavowed witnessed behavior





- Depersonalization; Loss of senses- kinesthetic, olfactory, auditory, vision (non-organic)
  - Engages in self harm and doesn't feel it- cutting, purging,
  - Risk taking behavior resulting in physical injury
  - Difficulty with mobility & collapse
- Non-organic pain

What Might People Infer if They Don't Know about Underlying Dissociation?

<u>Behavioral Explanations</u>

- Manipulative
- Oppositional

<u>Diagnostic Explanations</u>

- Bipolar Disorder
- Psychosis (e.g., Schizophrenia)
- Extreme Attention Deficit Hyperactivity Disorder (ADHD)
- Eating Disorder
- Obsessive Compulsive Disorder (OCD)
- Reactive Attachment Disorder (RAD)
- Autism

Case Examples

Marissa: age 10

Encopresis

Oppositional Defiant Disorder?

Marissa: age 10

Encopresis
Oppositional Defiant Disorder?

Jared, age 7

- Came for evaluation with presenting symptoms of:
  - Oppositionality
  - ADHD symptoms such as distractibility, “being in his own world”, “can’t concentrate”
  - Social challenges
  - Attachment challenges
  - Sensory- Motor issues (e.g., drooling)
  - “Brain Glitches”
- Diagnoses he came with:
  - ADHD
  - ODD
  - Rule out RAD
  - Rule Out Autism

Jared, age 7 – Autism?

- Not Autistic
  - Prosocial behaviors
  - Appropriate labelling of emotions
  - Perspective taking
  - Understood family dynamics

- Behaviors Explained by Early Neglect & Dissociation
  - Ambivalent about relationships
    - Family
    - Peers
  - Difficulty with Social Skills, especially with peers
  - Drooling as result of early and severe deprivation

  – is it a baby part?
  - Inner part– “Jason”– the ODD one?

Jared, age 7 – Autism?

- Not A[illegible]istic
  - [illegible]osc[illegible]ial behavio[illegible]
  - [illegible]ppropr[illegible]te labelli[illegible] of emotions
  - [illegible]erspective [illegible]king
  - U[illegible]derstood fa[illegible] dynamics

- Behaviors Explained by Early Neglect & Dissociation
  - Ambivalent about relationships
    - Family
    - Peers
  - Difficulty with Social Skills, especially with peers
  - Drooling as result of early and severe deprivation part?
  - Inner part– “Jason”– the ODD one?

Jared, age 14– What now?

Returned for a new evaluation 7 years later after multiple residential and inpatient stays

<u>Diagnoses he had accumulated:</u>

- PTSD, Depressive Disorder, Anxiety Disorder, Psychotic Disorder, Autism

<u>Medications:</u>

- Benztropine, Haldol, Trileptal, changed from Tenex, Cogentin, Geodon, and Haldol

Jared: Dissociation

- Current RTC staff saw no signs of autism, but saw zoning out and other possible dissociative symptoms

On evaluation….

- Scored high on the Child Dissociative Checklist, the Adolescent Dissociative Experiences Scale, and began to describe his “inside system” for the first time

Tressa, age 15

Conversion Disorder?

Somatic Symptom Disorder? (aka Somatoform Dissociation)

Other Specified Dissociative Disorder?

Factitious Disorder?

Personality Disorder?

Tressa, age 15

Conversion Disorder?

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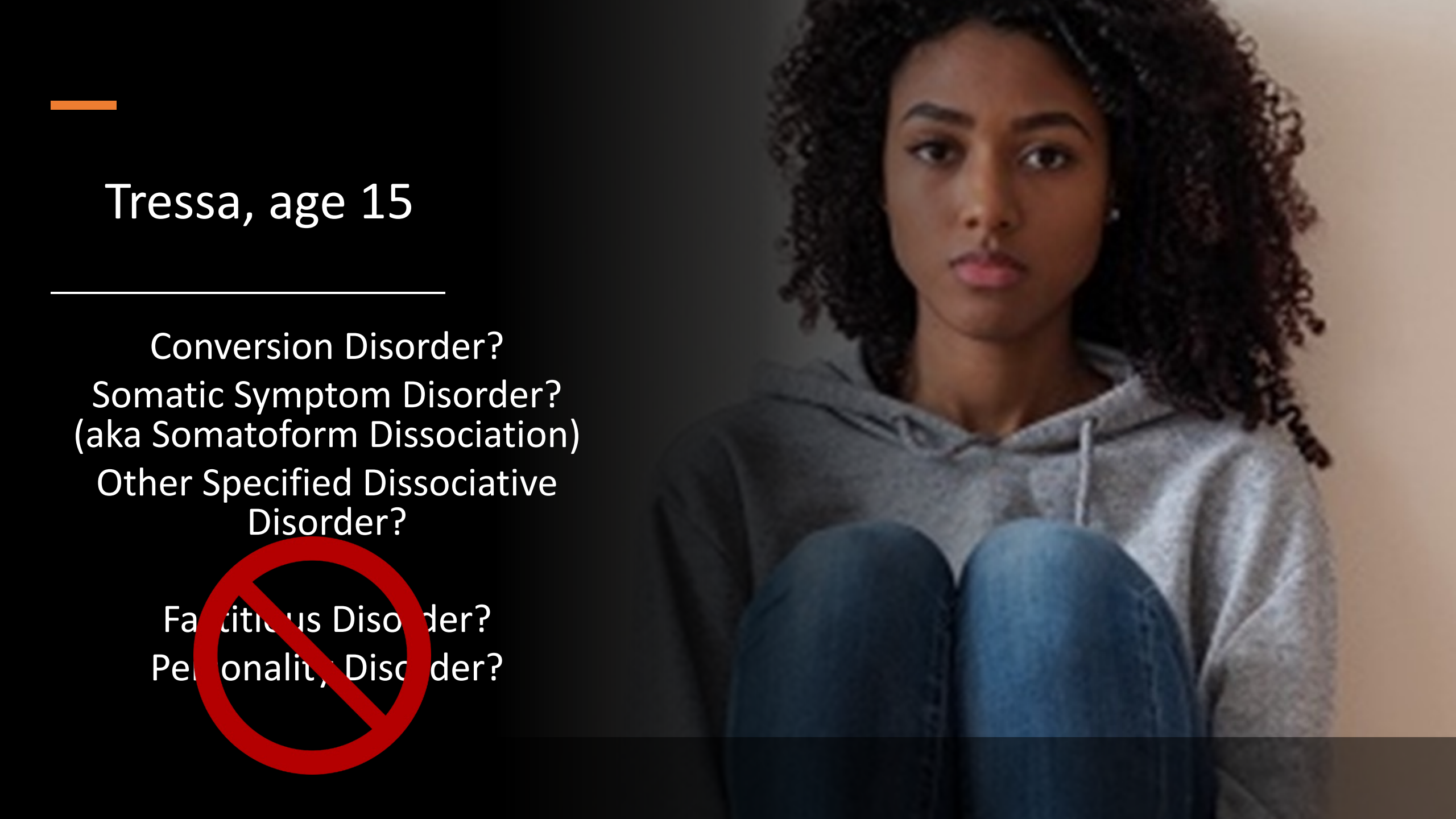
Personality Disorder?



Tressa, age 15

Historical reasons for conversion, somatoform, and other dissociative symptoms :

Major Attachment Disruptions

Jane, age 14

Psychiatrist ordered psychological evaluation to assess for:

Schizophrenia

Jane, age 14

- Looked/Acted young for age
- Withdrawn Socially/ Not engaged in school
- Poor hygiene
- Regressed states; “childlike”
- Changeable; different on different days
- Talks to Self – Hallucinations?
- Suicide attempt; now in residential facility
- Taking multiple medications including antipsychotics, sleep medicines, antidepressant

Symptoms of Schizophrenia

- “Positive Symptoms”
  - Auditory Hallucinations
  - Visual Hallucinations
  - Delusions
  - Thought Disorder “Alogia” – poor thinking inferred from confused, illogical, or vague language
  - Poor reality testing

- “Negative Symptoms”
  - Apathy: lack of interest in the world
  - Social Withdrawal
  - Anhedonia- Lack of pleasure Avolition (poor follow through)
  - Affective flattening (lack of emotions)
  - Struggle with the basics of life (e.g., poor hygiene)

Symptoms of Schizophrenia

SCID-D found 5 areas that differentiated Dissociative Disorders from Psychotic disorders:

- dissociative amnesia
- depersonalization
- derealization
- identity confusion
- identity alteration

[(Steinberg et al (1994) as reported in Moskowitz et al (2008)]

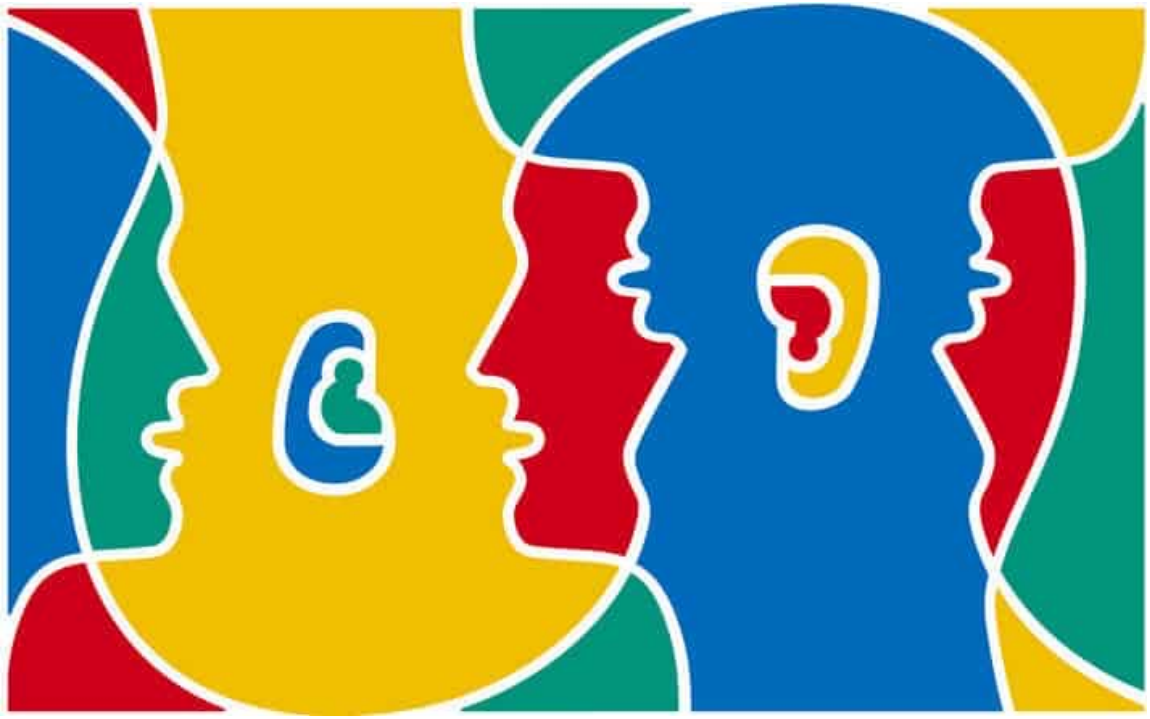
Jane, Age 14

Dissociative Identity Disorder

Not Schizophrenia

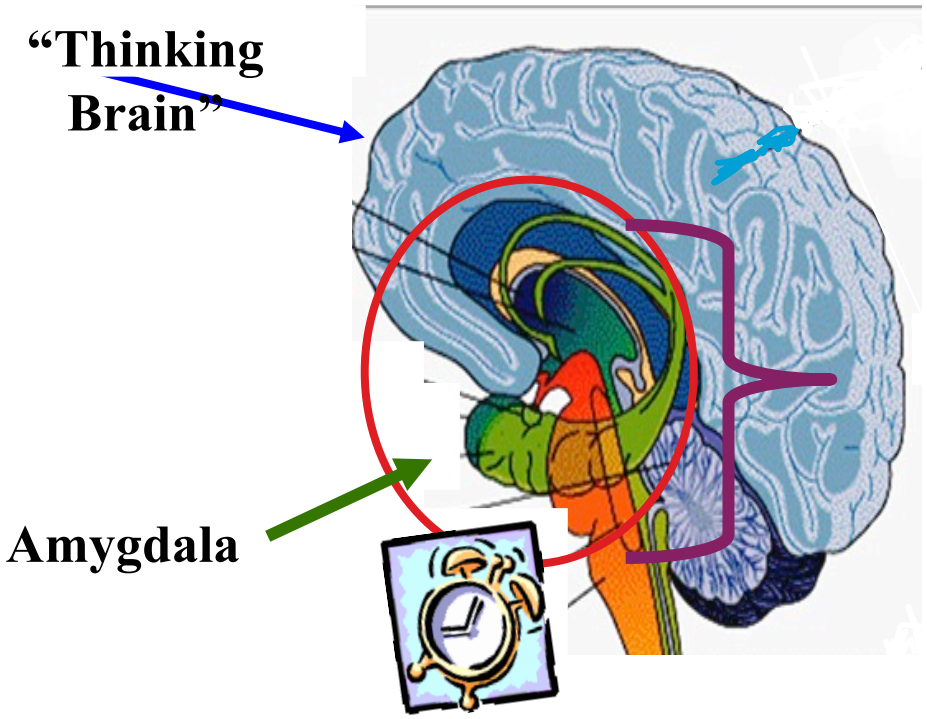
Auditory & Visual Hallucinations

- Difference between Psychotic & Dissociative Hallucinations
  - Dissociative hallucinations
    - Self-states may have "psychotic like thoughts" due to their limited understanding of the world & gaps in memory
    - Case example of Rudy



System Responses, through a non-informed lens, are often Punitive, Humiliating, Shaming, Frightening

Amygdala Alarm to Fire Alarm: a Story



"Reacting Brain"

Child with Autism Taken in Restraints in Police Car

Educate!

- System Reactivity

Common barriers to effective teaming when working with persons who have experienced Complex Trauma:

- Splitting/Triangulation
- Trauma Reminders
- Re-enactments
- Adult’s Own ACES
- Competing Agendas

Resist Splitting

- Avoid focusing solely on the client
- Explore what might be happening at the team or system level
- Facilitate openness and flexibility with a shared understanding of the youth's conflict
- Stay unified and connected to the youth through frequent teaming

Transference Countertransference

Professionals' Histories

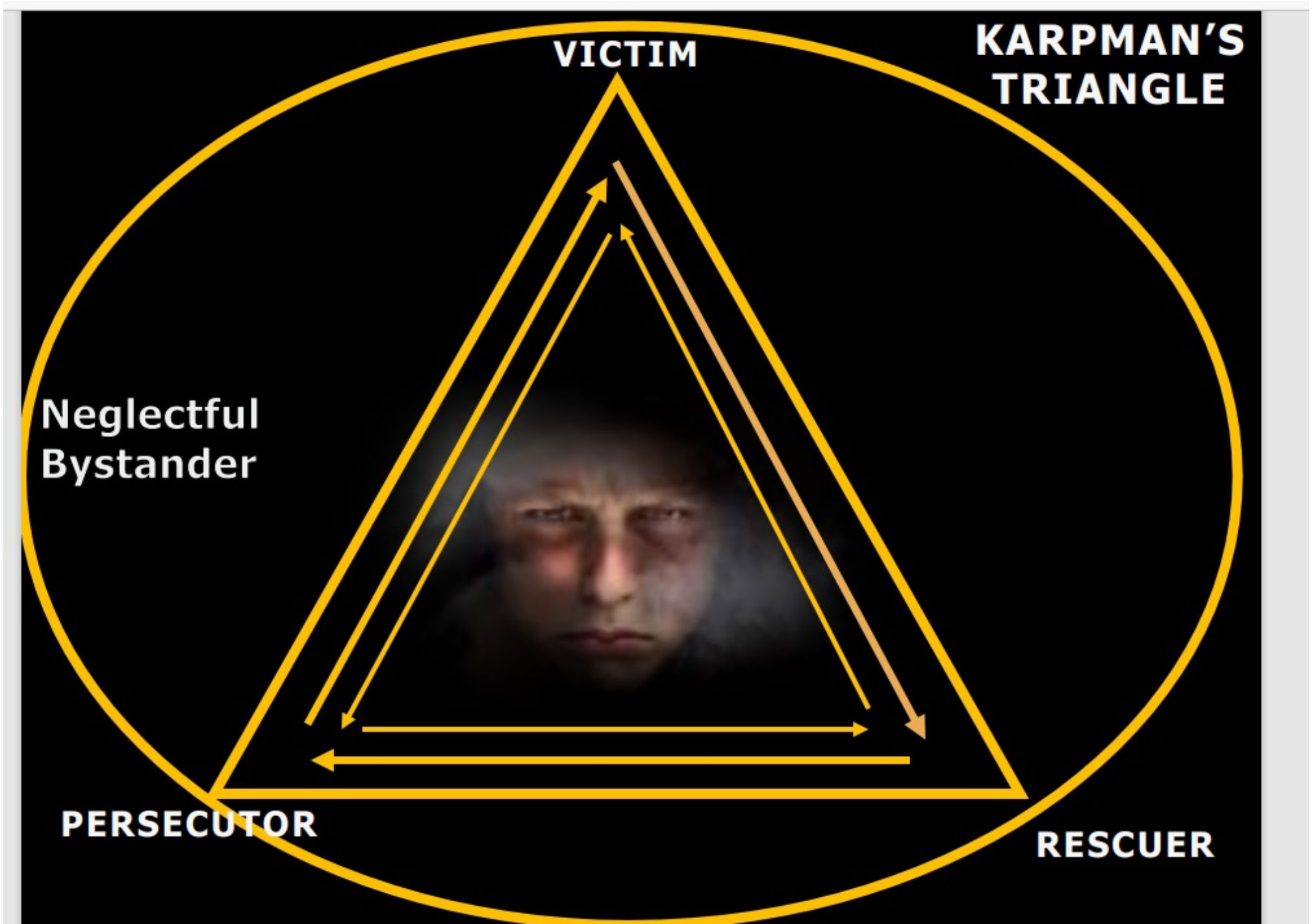
Systematic Responses

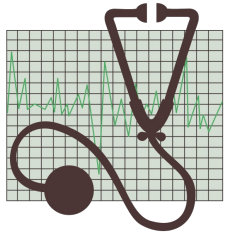
System Members: Our Emotional Responses

- Behaviors developed in a maltreating environment get replayed (enactment)
- These negative interactions can create intense emotions in adults in systems
- Adults who may feel pushed in unexpected ways can join unwittingly into a reenactment
- Blame the child; punish the child; reject the child
- Blame the other system(s)

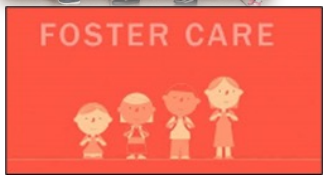
Individual Level:
All of us can "get on the Triangle" due to our own histories…

Now:
How about the Triangle at the System Level?





Victim



Karpman's Triangle Applied to Systems

Persecutor

Rescuer

System Solutions to Barriers?

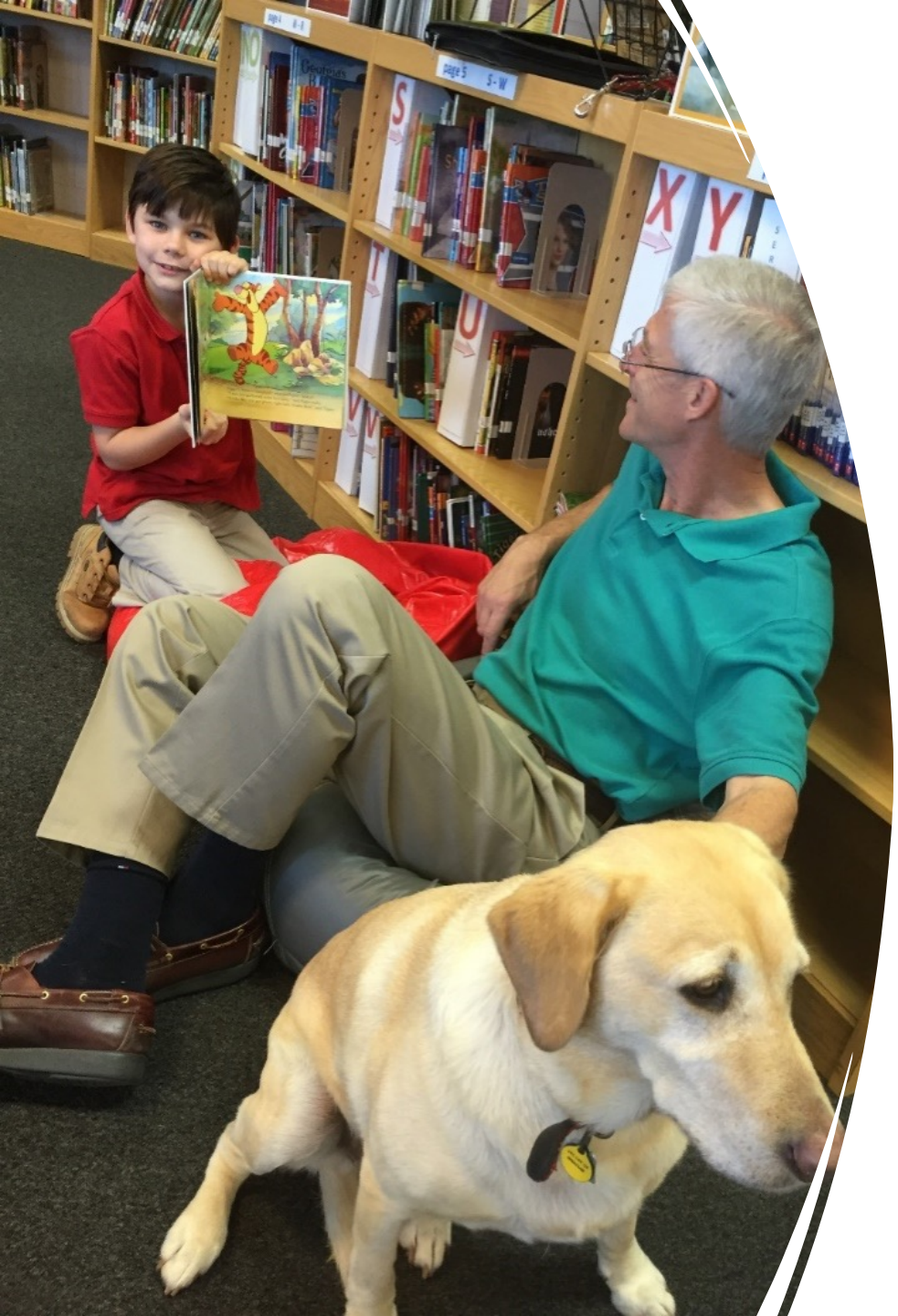
- Splitting/Triangulation
- Trauma Reminders
- Re-enactments
- Adult's Own ACES
- Competing Agendas

"It is collaboration that makes one feel safest by providing a reliable network of relationships allowing all members to feel secure enough to explore new ways of relating and behaving"

Dr. Jon Ebert, Vanderbilt University

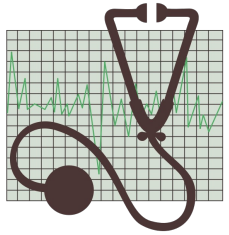
Story: Starring J

- The system came close to imploding around this 8-year-old boy
- Because some folks were able to see through a systemic trauma lens, we pulled off a couple of instrumental meetings to “put the puzzle pieces together”
- There is a happy ending… but it was tenuous, and many kids do not see these kinds of results
- It takes more time, more patience, and more vulnerability on everyone’s part



System

- Foster “to adopt” parents
- School – IEP
- Mental Health
- Foster care agency
- Child welfare
- Court



Victim

Karpman's Triangle Applied to Systems

Persecutor

Rescuer

Meeting #1

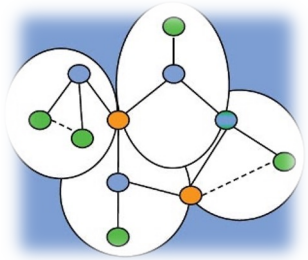
Meeting #2

Adoption Day!

We almost lost him to a frightened system…

- Education
- Residential
  - Mental Health
  - Substance Abuse
- Child Welfare
- Juvenile Justice
- Mental Health
- Pediatric Health
- Others?

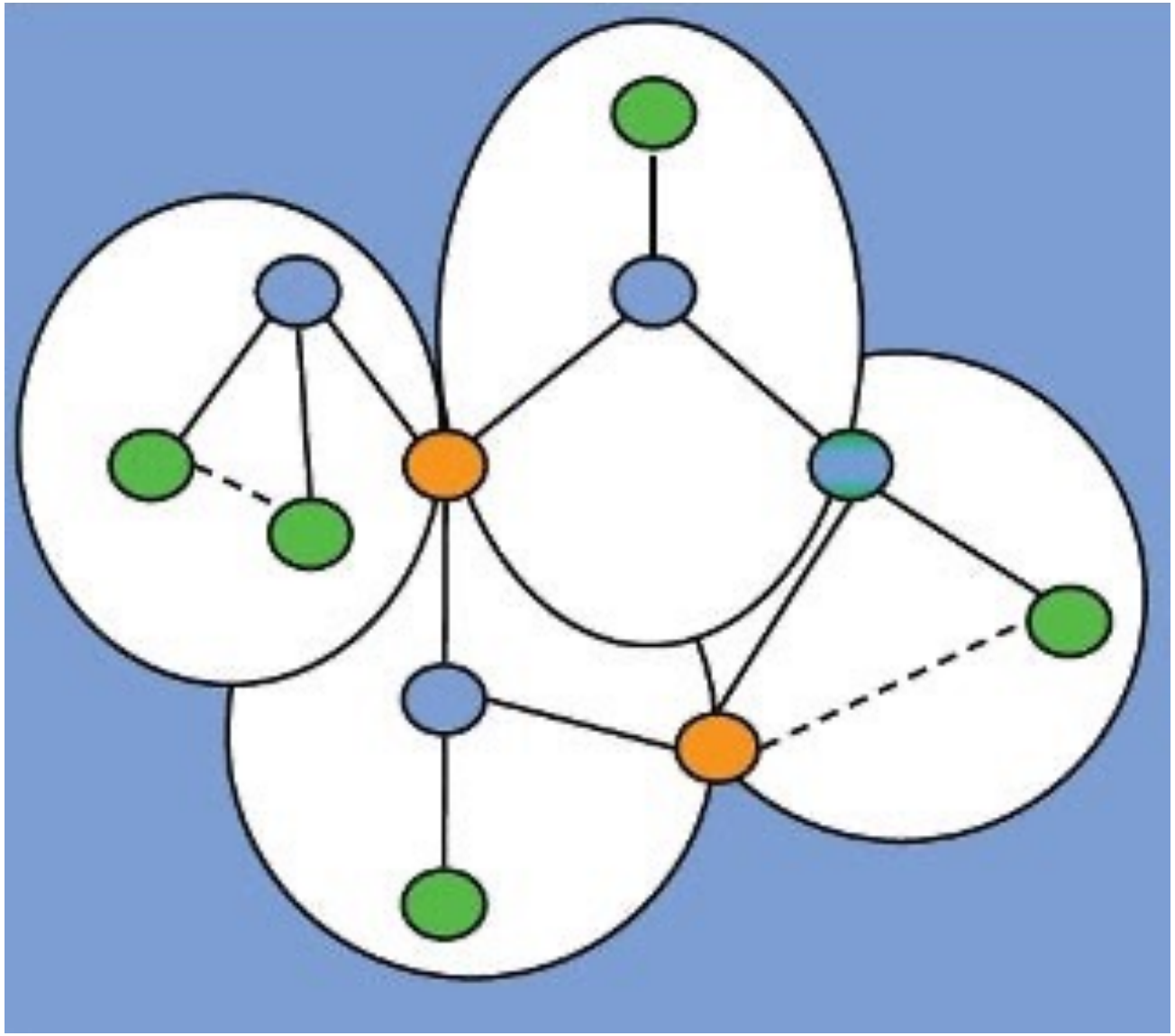
Child Serving Systems



Overarching Intervention Strategies Across Child Systems

Overarching Intervention Strategies Across Systems

- Consult & Advocate
  - Educate on Complex Trauma and Dissociation
  - Dispel Myths
  - Help find the missing links
  - Raise Awareness
  - Give resources
- Give Hope
  - Treatable with specialized intervention
  - Can integrate into society
- Model and Shape a Compassionate Attitude
  - Toward child
  - Toward family
  - Toward others in the system
- Contribute to Increasing Safety
  - Psychological
  - Physical
  - Across all parts of system and system levels



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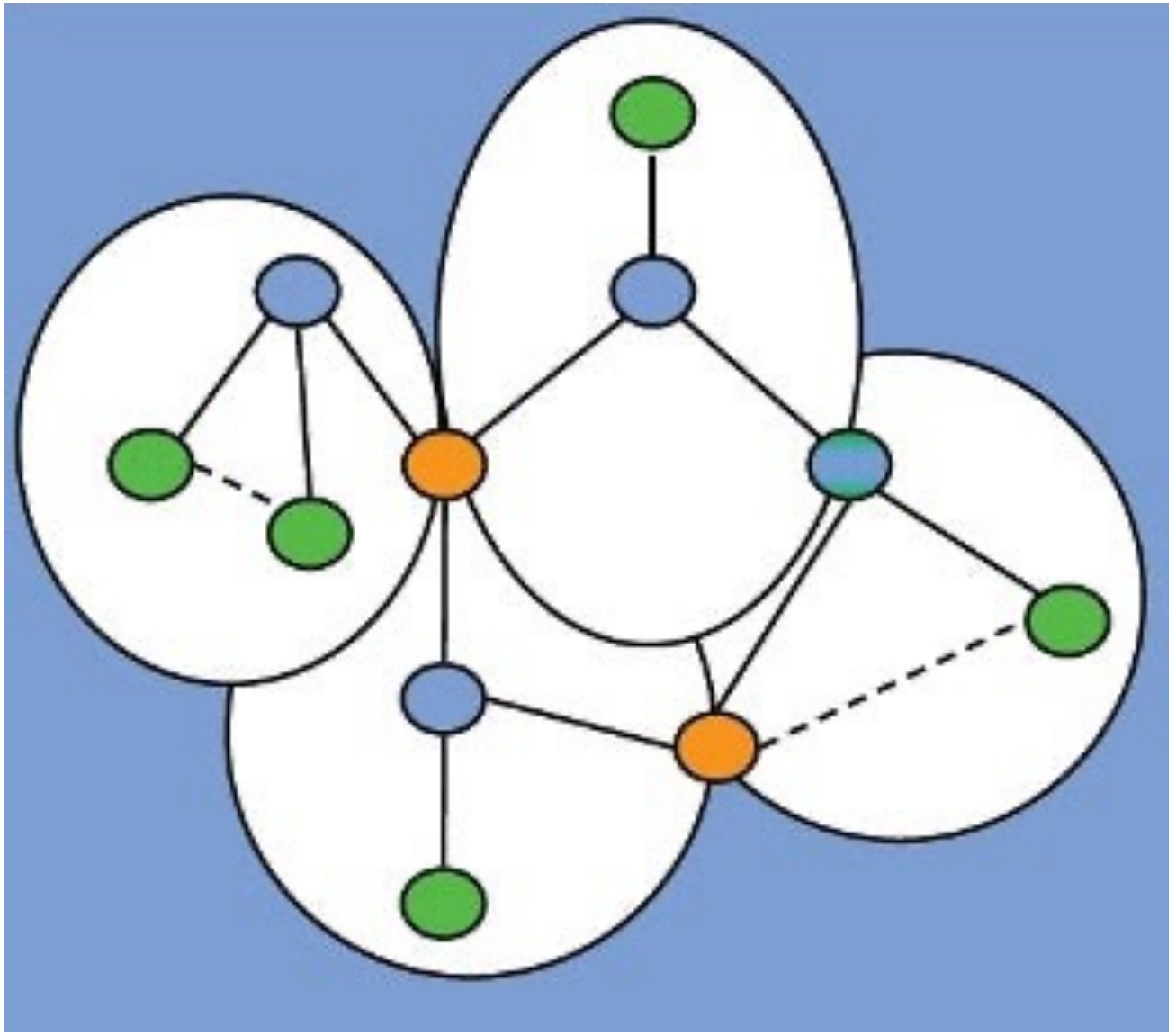
Overarching Intervention Strategies Across Systems

- Explain Dissociation and Self-States
  - Important: Only one person with separate states of consciousness we call “self states”
  - Self States form as a survival technique to segment off the traumatic events
  - Reflects an adaptive (creative) ability to develop internal helpers (e.g., protectors)
  - Identifies with known people in child’s life, hero figures, etc.



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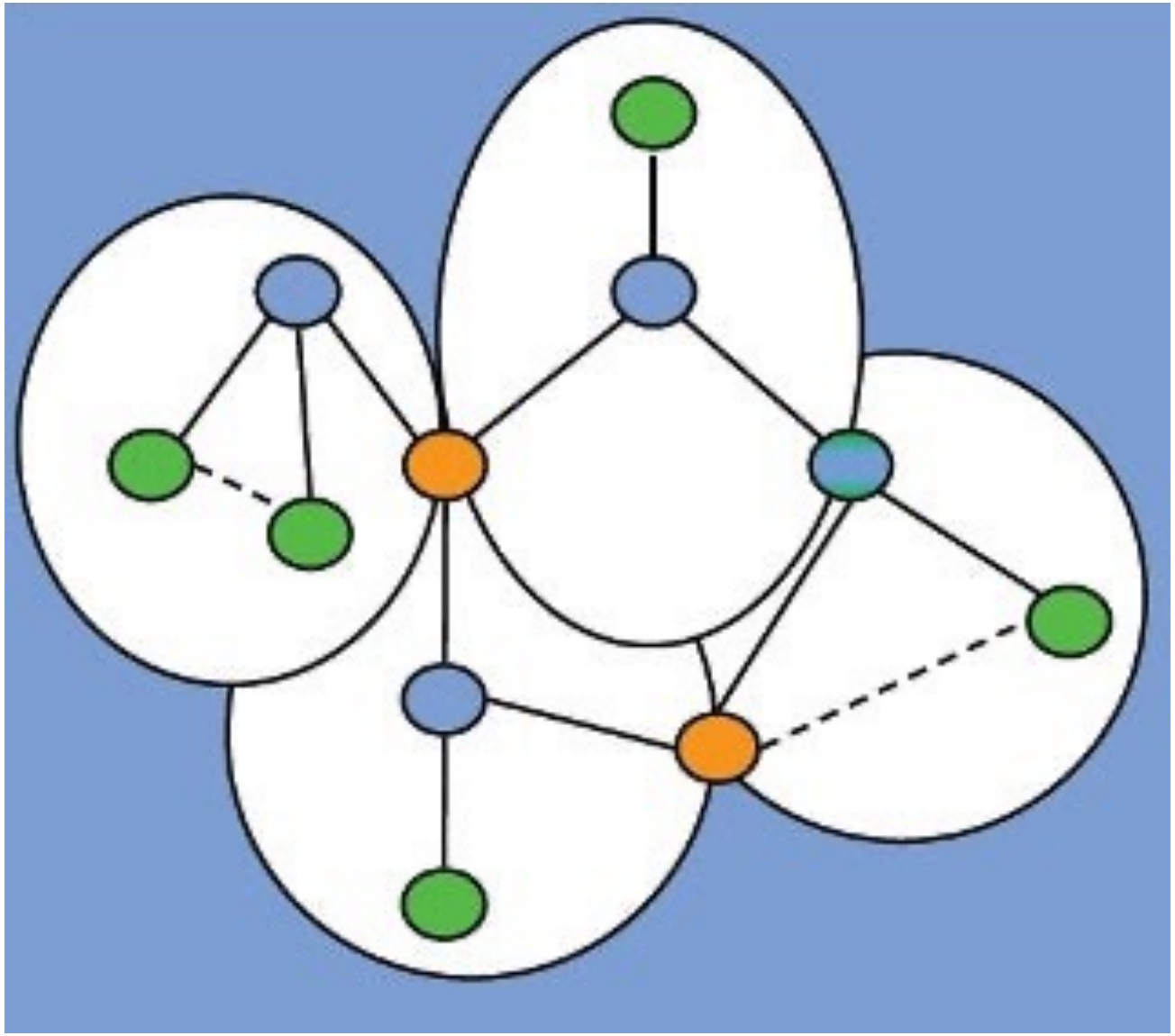
Overarching Intervention Strategies Across Systems

- Demystify aggressive self-states
  - Common to identify with abuser to feel powerful to compensate for helplessness
  - Referred to as “angry parts”
  - Masking deep pain
  - Form of protection
  - Angry parts haven’t yet learned effective outlets
  - Reframe into helpers



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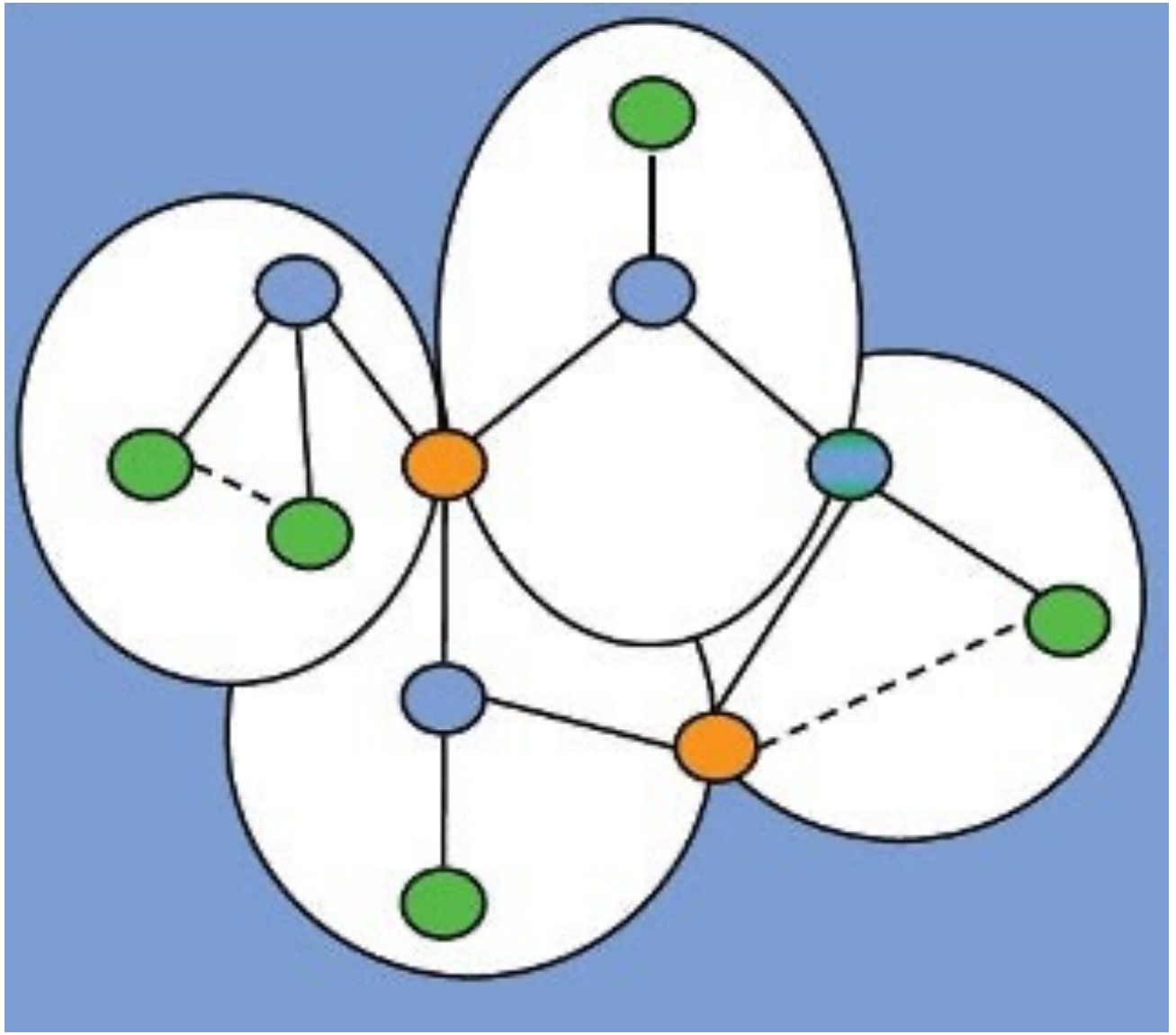
Overarching Intervention Strategies Across Systems

- Give Accessible Language for Dissociation
  - Automatic defense mechanism
    - Overwhelming fear, helplessness
    - Survival “Escape hatch”



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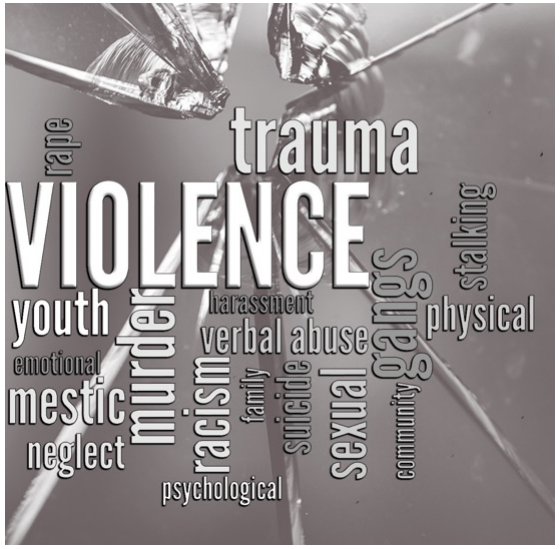
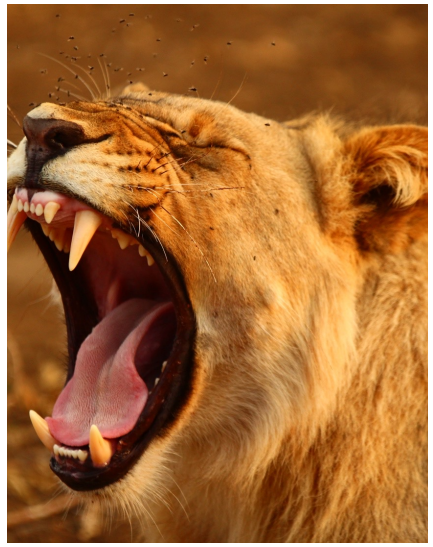
Systemic
Stigmatization

Sexualized
Self-harming
Aggressive
Encopresis
Eating Disorders

Dynamics of “Lion” Self-States





Often reason for treatment

Often resistant to typical treatment

Internalize the toxic information from the violence they incurred

Dynamics of “Lion” Self-States

- Projective identification with abusers
- Still stuck in the traumatic memory or affect of rage
- Phobic of fear, helplessness, weakness, lack of control
- Disconnected from emotional & physical pain

Dynamics of “Lion” Self-States

- Safety is paramount
- Divide & conquer for power
  - Aggressive/destructive
  - Suicidal
  - Homicidal
- All about protection with force
- **Unattached**

Dynamics of Lion Self-States
Reenactments of violence they experienced

- Expresses rage on child or self-states for expression of rage
  - Blames child for trauma
  - Sees child as weak
  - Revengeful
    - Incurs cutting, purging, drugs, suicidal behavior
- Turns on others in environment for expression of rage
  - Aggression
  - Homicidal
  - Destructive

Successful Outcomes in System

With…

- Patience
- Collaboration
- Education

Case Example: Taming the Lions!

- **Child**
- **System**

Turf Issues & Consequences with DID Child
New Residential Placement
Informed Dissociative Treatment Approach
Integrative Intervention

- Residential team on board with unified approach
- Residential therapist works well with child & family
- My ongoing consultation and co-therapy continues

New Residential Placement

Informed Dissociative Treatment Approach

Integrative Intervention

Informed & uniform approach re: self-states in treatment, educational & recreational domains

Calming, sensory room

Rewards system

Taming the Lion-Aggressive States

Overarching Goal

Build Attachment Across the System

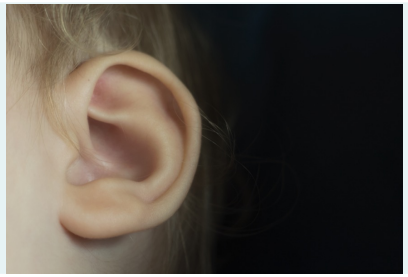
Build	Resolve	Reframe	Replace	Release	Redefine
Most important tasks is to build a relationship with the lion • Staff & therapist not seen as a threat • Empathic approach • Develop safe and positive transference	Resolve their attachment to the perpetrator(s)	Reframe negative thoughts of worthlessness & weakness	Replace their identity from aggressor to protector in a healthy way	Release negative affect safely	Redefine strength

Specialized Interventions

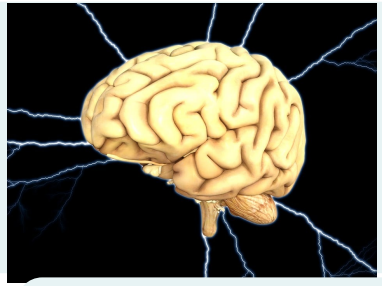
All of Me & the 7 L's in Unity

Look

Listen



Learn



Love

Laugh

Live

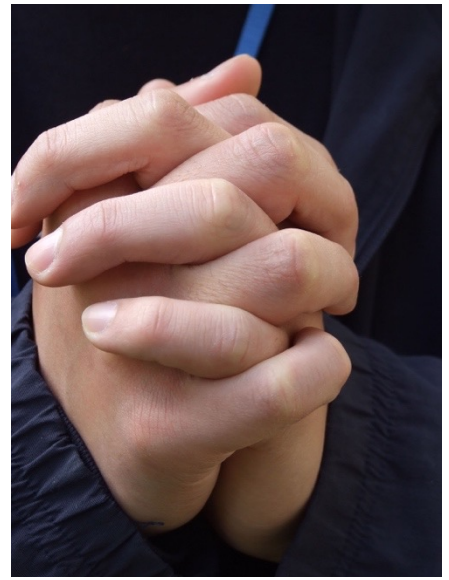
Lessons learned

Waters, F., 2022

Building Internal Awareness & Unity

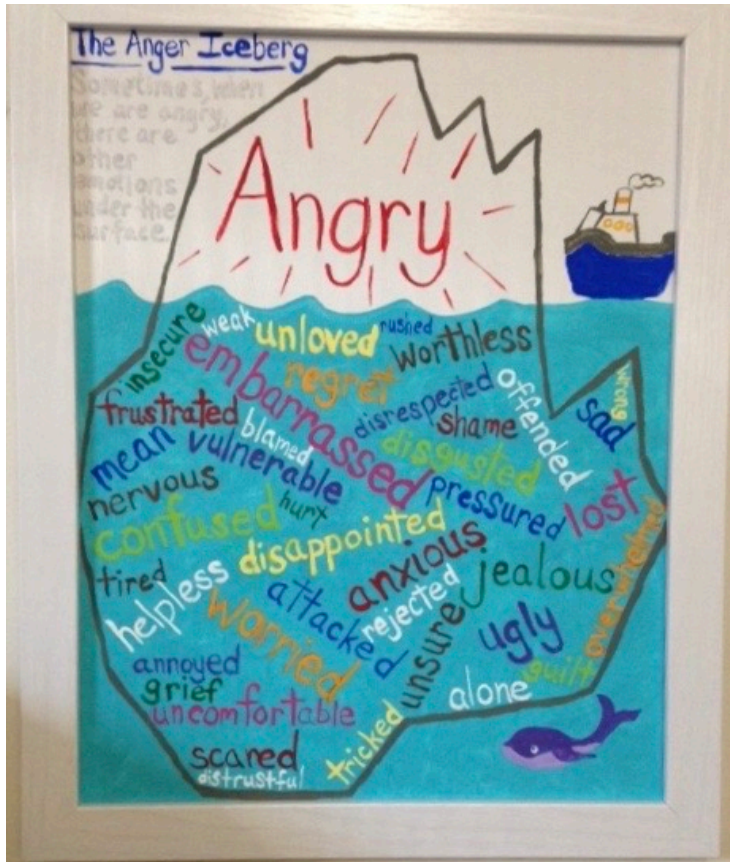
- 7 L's
  - Look
  - Listen
  - Learn
  - Love
  - Live
  - Laugh
  - Lessons learned

When we work together, we do much better.



Regulation across Child's States

Examine below the "The Anger Iceberg" & States Feelings



Sometimes when we are angry, there are other emotions under the surface.

@ Waters, F, 2021

Redefining Strength

Internal Power

CAPS

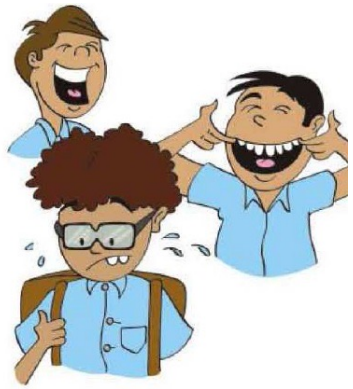
Cooperation
Assertive
Persistence
Self Control

v

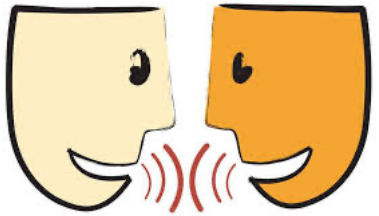
Redefining Power

External Power

Verbal & Physical Aggression



Making fun of a child



Date:

WINDOW OF TOLERANCE, Waters, F.

Name:

Hyperarousal

Reflections from all of me (list)

Angry

Sad

Window of Tolerance

Hypoarousal

Blank

Expanding the Window of Tolerance

What size is your widow of tolerance?

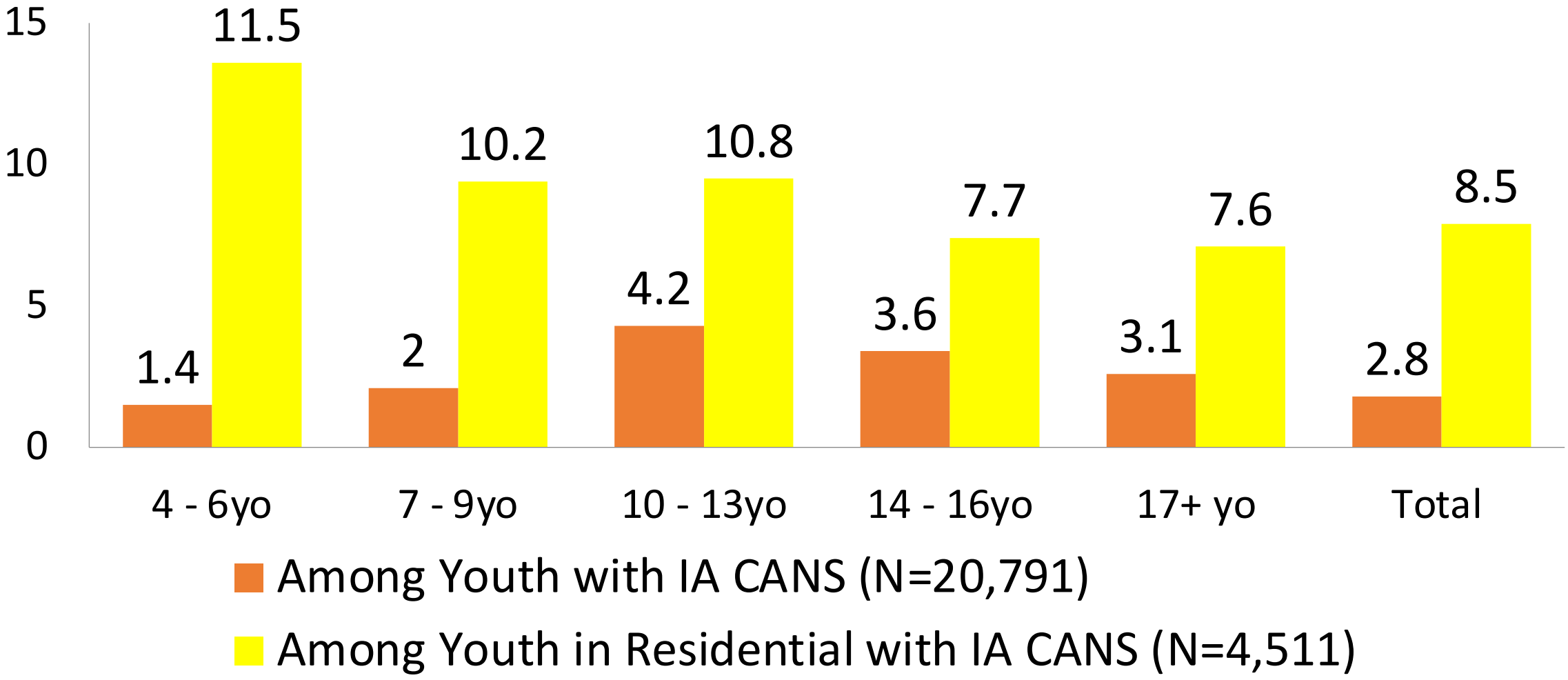
Systematic Integrative Outcomes

Systematic Integrative Outcomes:

Child Welfare

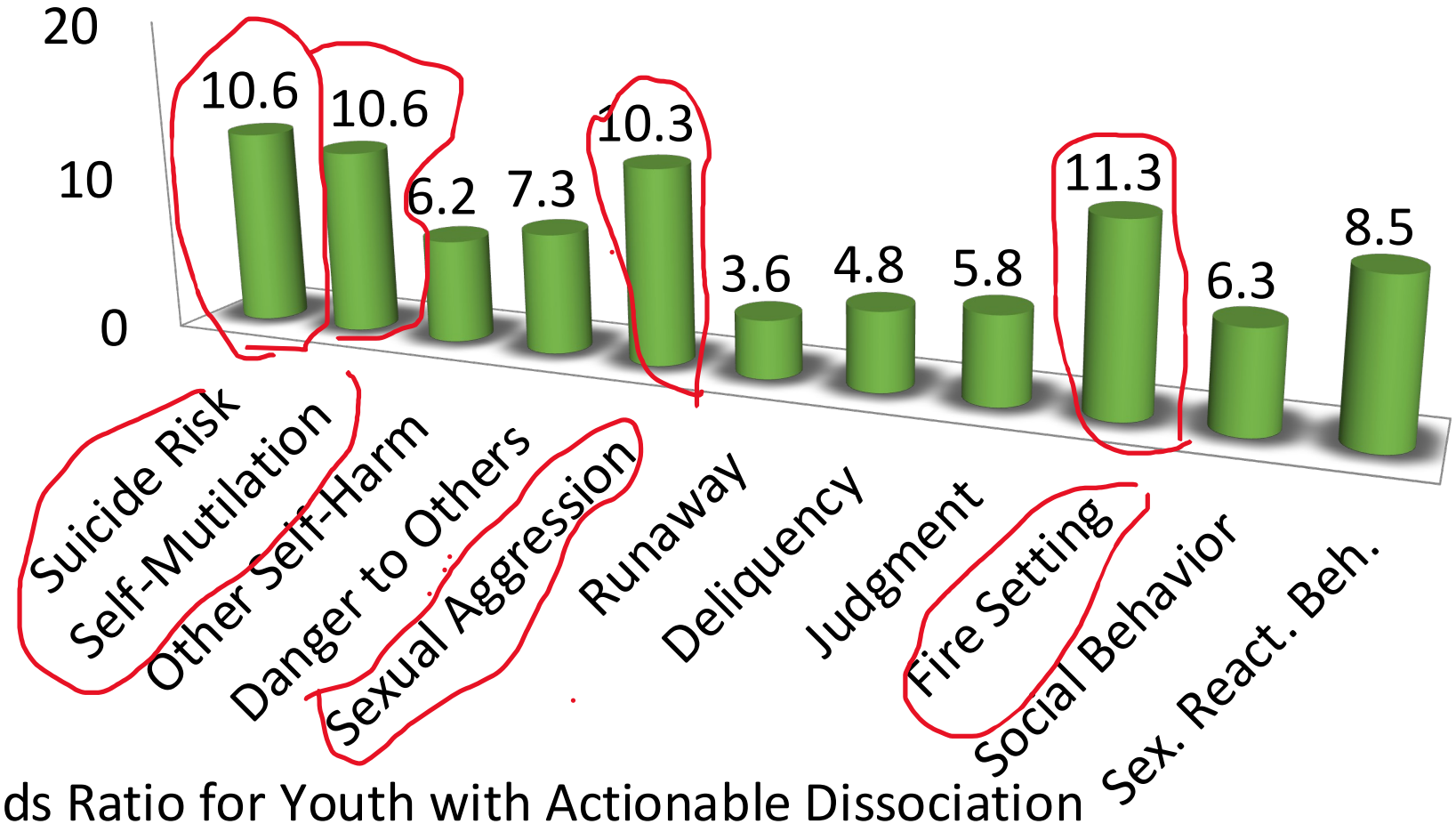
Clinically Significant Dissociation on the CANS: Entry into Illinois Child Welfare (N=27,737) and Residential Placement (N=5,758)

Kisiel, C. L., Torgersen, E., & McClelland, G. M. (2020)



Odds of Significant Risk Behaviors by Significant Dissociation based on the CANS: Entry into Illinois Child Welfare (N=27,737)

Kisiel, C. L., Torgersen, E., & McClelland, G. M. (2020)



Little House on Lincoln Street

Multi Disciplinary Team Model

National Children's Advocacy Center

2008 APSAC Media Award from ISSTD

DVD Clip:
Guidelines for Prosecutors (edited)

Presenters:

John EB Meyers, JD
Victor Veitch, JD
Connie Carnes, MS LPC
Renee Potgieter Marks, PhD

See resources at end for more information

US v. Albert J. Kappell
Native American Case History

- Kappell repetitively sexually abused girlfriend's 2 young daughters- 7 & 4 years old
- Kappell put his hand over 4 y.o. threatening to kill them if she told
- Mother told daughters not to tell several times because she wanted to marry Kappell
- Girls were interviewed by tribal social services & 2 pediatricians and gave reports verbally and non-verbally about their abuse

Federal Case on Indigenous Children

Mental health assessment for purpose of diagnosis & treatment

Expert testimony allowed

Forensically Sensitive Extended Assessment Based on NCAC Goals

- Forensically guided questions
- Affords the child to build trust, rapport, degree of safety → **Avoid shutdown-Dissociative reactions**
- Affords the interviewer to be attuned to child's distress, need for space
- Affords the interviewer to pace questions carefully
- Affords the child the likelihood to disclose multiple incidents over time with details
- Affords the interviewer to clarify any discrepancies

US v. Albert J. Kappell
Case History

- I did 6 interviews for purpose of diagnosis and treatment following NCAC's forensically sensitive extended interview
- After 1st interview mom absconded with the children & crossed state lines
- Police picked up children and returned them to grandmother
- Mom was denied visitation

US v. Albert J. Kappell
Case History

- I resumed my evaluation
- I emphasized to the children the importance of telling the truth & confirmed that they understood
- When discussing who they lived with, they showed traumatic reactions at mention of abuser
  - 4 y.o. would dissociate
  - 7 y.o. would cry covering her face
  - Older child witnessed younger sister's abuse

US v. Albert J. Kappell
Case History

- Over the next several sessions, the children were able to provide details of their sexual abuse

US v. Albert J. Kappell Hearing

- Closed Circuit TV & Children's Testimony
  - 4 y.o. girl stared off & unable to disclose
  - 7 y.o. girl cried in court & unable to disclose

US v. Albert J. Kappell Hearing

- Federal Courts allow testimony of mental health assessments for purpose of diagnosis and treatment
- Witnesses were sequestered
- I testify in court about my mental health assessment following NCAC guidelines
- I testify about the children's reactions & dx. PTSD
  - 4 y.o. dissociated
  - 7 y.o. cried

US v. Albert J. Kappell
Verdict

- Jury found him guilty of 6 counts of sexual abuse
- Sentenced to life in prison

US v. Albert J. Kappell
Appeal

- Basis of appeal
  - Constitutional right to be faced by/confront the accuser
  - Hearsay testimony by expert
  - Challenges his sentence of life imprisonment under § 2241(c) based on his plea agreement of prior state conviction for child sexual abuse

US v. Albert J. Kappell
Appeal Denied

- Basis of denial
  - Kappell agreed to children's testimony via close circuit TV & they were cross examined
  - Federal Rule of Evidence 803(4), the hearsay exception for "statements for purposes of medical diagnosis or treatment," and Waters was vigorously cross examined
  - Upheld life sentence with prior convictions of sex offenses

US v. Albert J. Kappell
Appeal Denied
Landmark Case

- *A young child, even one who was four years old and incompetent to testify in a sexual abuse case, has a strong motive to 'make true statements for the purposes of diagnosis or treatment[.]'*

Educate!

- Useful Resources
- Getting on the Same Page

International Society for the Study of Trauma and Dissociation

www.isst-d.org

2008 APSAC Media Award

Trauma & Dissociation in Children

3 Part DVD

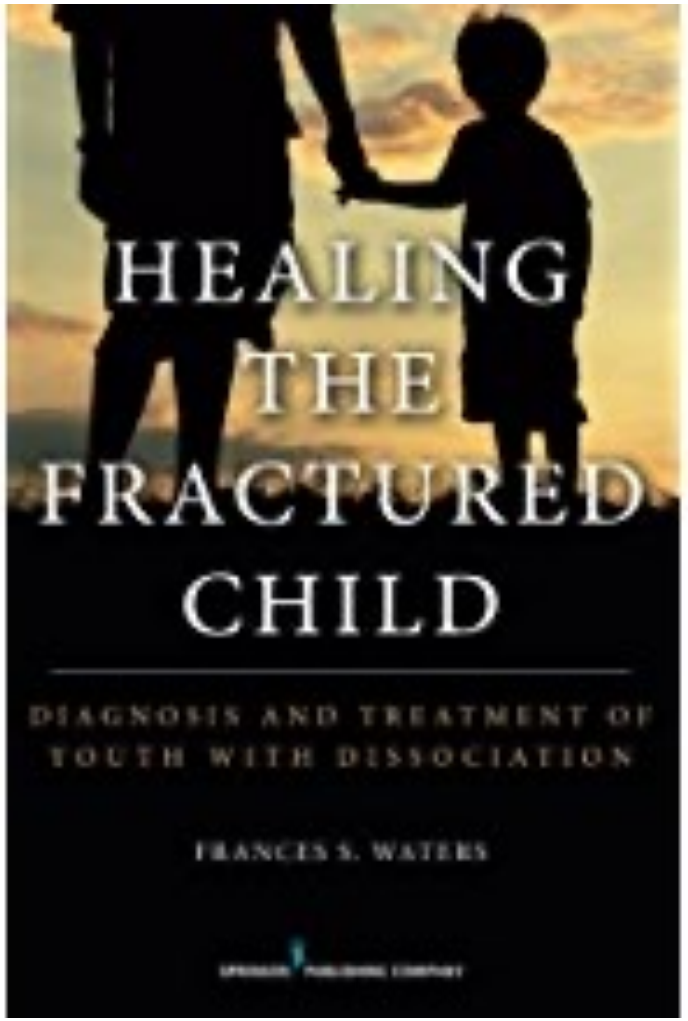
Behavioral Impact, Interviewing Issues, Guidelines for Prosecutors

Fran S. Waters

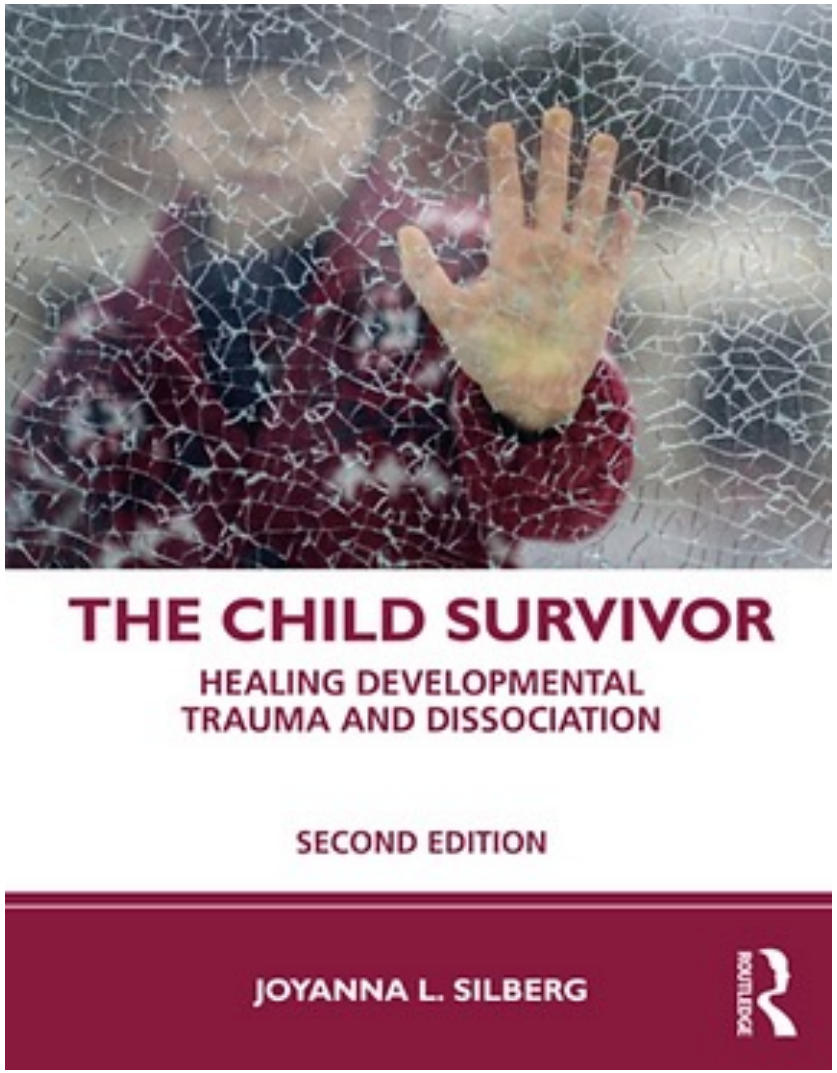
ISSTD's Executive Producer

Purchase at www.isst-d.org

Definitive and Current Sources on Childhood Dissociation



2016



2022

12 core concepts of Understanding Traumatic Stress Responses

See handout of the 12 Core Concepts

NCTSN The National Child Traumatic Stress Network

The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families Adapted for Youth Who Are Trafficked

The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families provide a rationale for trauma-informed assessment and intervention. The Concepts cover a broad range of points that practitioners and agencies should consider as they strive to assess, understand, and assist trauma-exposed children, families, and communities in trauma-informed ways.

1. **Traumatic experiences are inherently complex.**

Every traumatic event is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. The moment-to-moment reactions youth have to these individual events are even more complex due to limitations in appraising and responding to danger, safety, and protection. When youth are sold for sex or labor, they constantly receive information that they must weigh and react to quickly. Thoughts come quickly and continuously: "What do I need to do to survive this? What's worse, if he rapes me or kills me? If I don't do what they say, what will they do to me? If I don't do this, will my 'boyfriend' will be angry?"

2. **Trauma occurs within a broad context that includes youth's personal characteristics, life experiences, and current circumstances.**

Early interpersonal trauma may make youth more vulnerable to trafficking, teaching them not to trust others and to survive by any means necessary even if that involves further maltreatment. How they deal with, respond to, and cope with these situations stems from their current experience (e.g., a strong bond with the trafficker), the accumulation of their past experiences (e.g., childhood sexual abuse, domestic violence), and temperament as well as their physical, familial, community, and cultural environments.

3. **Traumatic events often generate secondary adversities, life changes, and distressing reminders in youth's daily lives.**

Some trafficked youth cannot escape a constant flood of painful and demoralizing reminders of past traumatic events or moments. Reminders can be anything that a youth associates with a traumatic experience (i.e., smell of alcohol, cologne, or sweat, certain locations) whether large or small, obvious or unknown. Reminders occur when least expected and youth may react with avoidance, numbing, hypervigilance, re-experiencing, or other responses. Traumatic events often generate secondary adversities such as social stigma, ongoing treatment for injuries, and legal proceedings. These adversities coupled with trauma reminders and loss reminders may produce significant fluctuations in a youth's emotional and behavioral functioning.

4. **Youth can exhibit a wide range of reactions to trauma and loss.**

Due to past or on-going trauma, youth may respond to everyday challenges with rage, aggression, defiance, recklessness, or by bonding with aggressors. Others may withdraw, emotionally shut down, dissociate, self-harm, or self-medicate.

5. **Danger and safety are primary concerns in the lives of youth who have had traumatic experiences.** Trafficked youth may believe that no person, relationship, or place can ever be safe or trustworthy. Continual exposure to traumatic experiences can make it more difficult for youth to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior.

NCTSN The National Child Traumatic Stress Network

6. **Traumatic experiences affect the family and broader caregiving system.**

Parents, caregivers, family members, and friends may want to help a youth who has been trafficked, but they may not know how to regain the youth's trust or how to help the youth envision a life that doesn't involve being trafficked.

7. **Protective and promotive factors can reduce the adverse impact of trauma.**

Supportive adults and communities, strong social connections, positive mentors, high self-esteem, and good coping skills can buffer the effects of trauma experienced by trafficked youth. When given the opportunity, many trafficked youth demonstrate remarkable resilience and enormous capacity to heal.

8. **Trauma and post-trauma adversities can strongly influence development.**

Trafficked youth may have had many interruptions and interference in their childhood (e.g., innocence, playfulness, creativity) and adolescence (e.g., autonomy, intimacy, self-definition) causing a disruption in healthy development.

9. **Developmental neurobiology underlies youth's reactions to traumatic experiences.**

Trafficked youth may develop "survival brain"—an automatic focus on anticipating or counteracting danger rather than letting down their guard—especially when life seems safe (the times when they have most often been blindsided by victimizers).

10. **Culture is closely interwoven with traumatic experiences, responses, and recovery.**

Every trafficked youth has a unique set of past and current cultural experiences, values, beliefs, and expectations. Youth may feel conflicted with by divided loyalties when cultures clash.

11. **Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.**

Trafficked youth may have lost hope that society, especially people with power (such as law enforcement or judicial professionals) will fulfill their societal mandate to protect and help them. Vulnerable to criminalization, stigmatization, and victimization, youth often resist and are distrustful of the authority of those they perceive as unwilling and unable to help. Some of the distrust is due to the instances in the past when these systems have failed them.

12. **Working with trauma-exposed youth and their families can be extremely rewarding.**

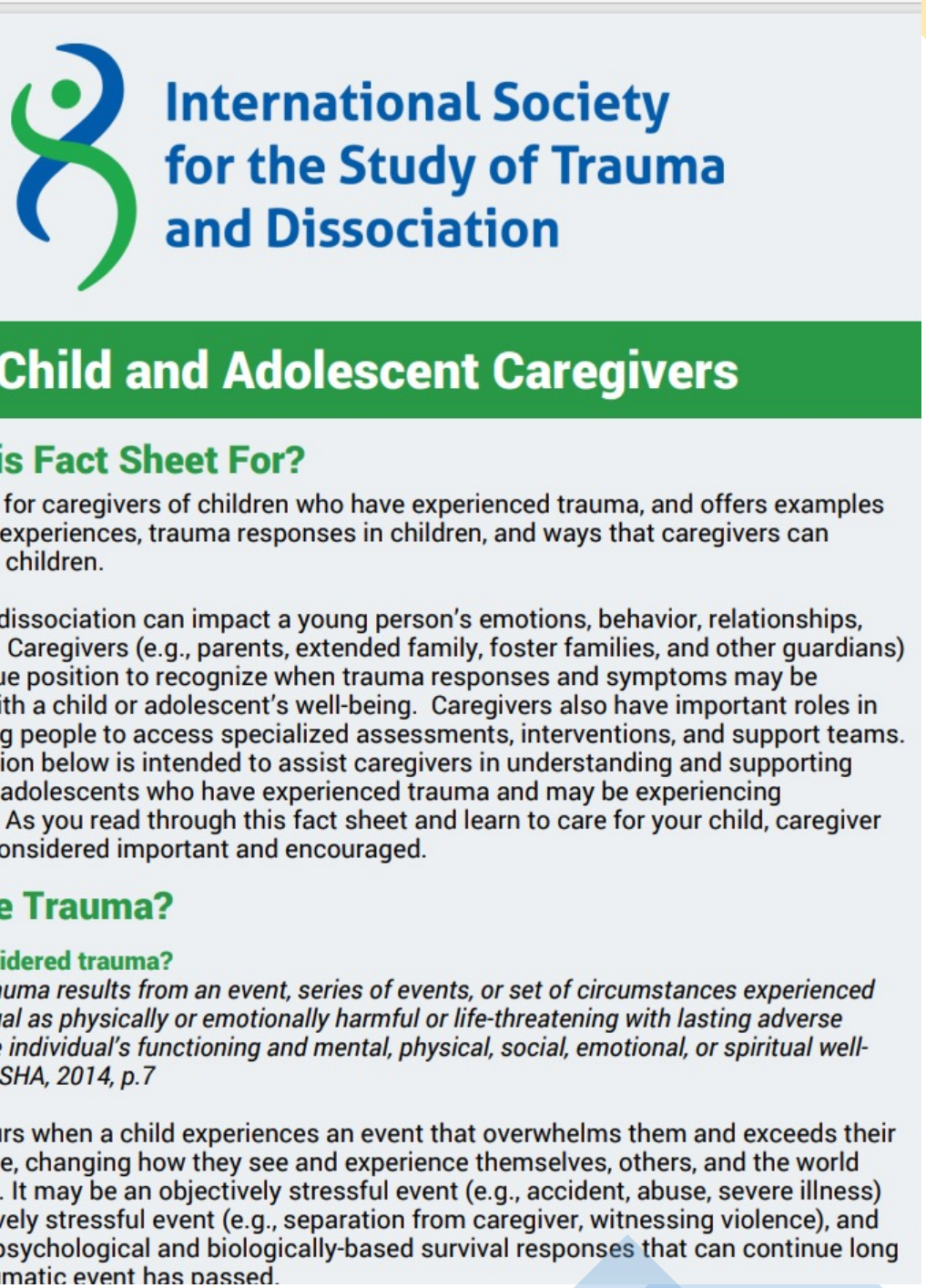
Adults who come to know trafficked youth in the course of providing them with services may be deeply affected by hearing about the tragedy and horror of these youths' experiences. It is imperative for these adults to take care of their own emotional and physical health in order to be able to thoughtfully and consistently helpful to trafficked youth.

For more information on *The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families*, please visit www.NCTSN.org

The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families, Adapted for Youth Who Are Trafficked
ww.NCTSN.org

[Child & Adolescent Fact Sheet - For Caregivers - ISSTD (isst-d.org)]

(See handout)



International Society for the Study of Trauma and Dissociation

Child and Adolescent Caregivers

Who is this Fact Sheet For?

This sheet is for caregivers of children who have experienced trauma, and offers examples of traumatic experiences, trauma responses in children, and ways that caregivers can support their children.

Trauma and dissociation can impact a young person's emotions, behavior, relationships, and learning. Caregivers (e.g., parents, extended family, foster families, and other guardians) are in a unique position to recognize when trauma responses and symptoms may be interfering with a child or adolescent's well-being. Caregivers also have important roles in helping young people to access specialized assessments, interventions, and support teams. The information below is intended to assist caregivers in understanding and supporting children and adolescents who have experienced trauma and may be experiencing dissociation. As you read through this fact sheet and learn to care for your child, caregiver self-care is considered important and encouraged.

Could it be Trauma?

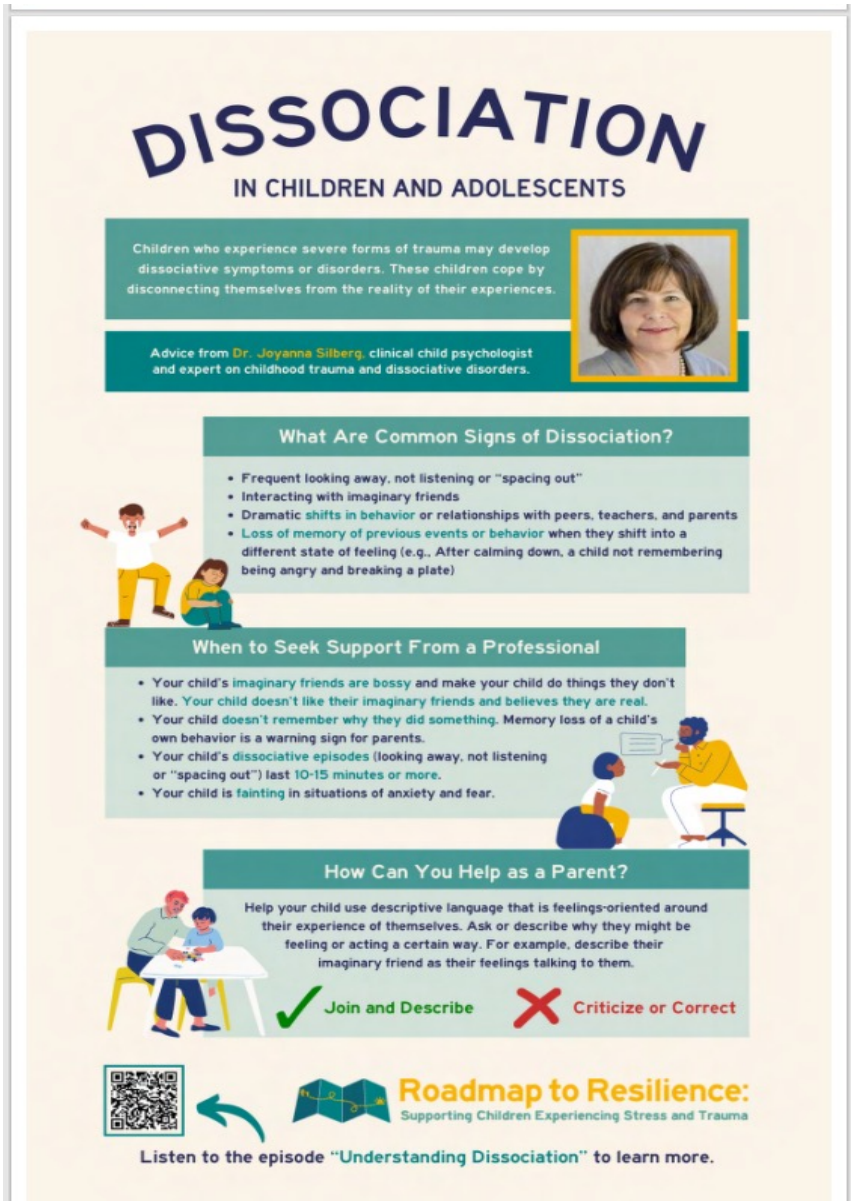
What is considered trauma?

"Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."--SAMSHA, 2014, p.7

Trauma occurs when a child experiences an event that overwhelms them and exceeds their ability to cope, changing how they see and experience themselves, others, and the world around them. It may be an objectively stressful event (e.g., accident, abuse, severe illness) or a subjectively stressful event (e.g., separation from caregiver, witnessing violence), and may lead to psychological and biologically-based survival responses that can continue long after the traumatic event has passed.

Podcasts!

[Roadmap to Resilience](#) (See handout)



[Roadmap to Resilience] (See handout)

Podcasts!

Examples

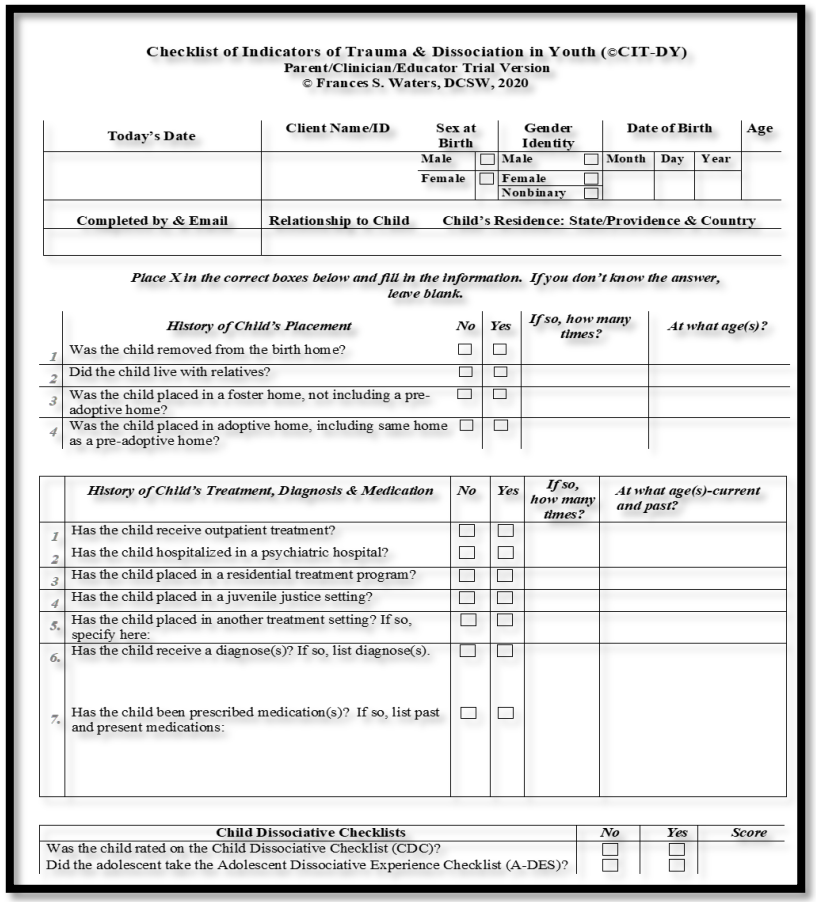
Frances Waters on Child Dissociation Podcast for System Speaks

https://cdn.transistor.fm/file/transistor/m/shows/580/d42ea7afba028d6b2d078b76c2d3c4d4.mp3

Checklist of Indicators of Trauma & Dissociation in Youth- CIT-DY V3.1 ©Frances S. Waters, 2020

- **Parent Checklist (CIT-DY V3.1)**
- **Youth Self-Report (CIT-DY V3.1)**

Print & Computer Versions (Free)



Checklist of Indicators of Trauma & Dissociation in Youth (©CIT-DY)
Parent/Clinician/Educator Trial Version
© Frances S. Waters, DCSW, 2020

Today's Date	Client Name/ID	Sex at Birth	Gender Identity	Date of Birth	Age
		Male ☐ Female ☐	Male ☐ Female ☐ Nonbinary ☐	Month Day Year	
Completed by & Email	**Relationship to Child**	**Child's Residence: State/Providence & Country**			

Place X in the correct boxes below and fill in the information. If you don't know the answer, leave blank.

	History of Child's Placement	*No*	*Yes*	*If so, how many times?*	*At what age(s)?*
1	Was the child removed from the birth home?	☐	☐		
2	Did the child live with relatives?	☐	☐		
3	Was the child placed in a foster home, not including a pre-adoptive home?	☐	☐		
4	Was the child placed in adoptive home, including same home as a pre-adoptive home?	☐	☐		

	History of Child's Treatment, Diagnosis & Medication	*No*	*Yes*	*If so, how many times?*	*At what age(s)-current and past?*
1	Has the child receive outpatient treatment?	☐	☐		
2	Has the child hospitalized in a psychiatric hospital?	☐	☐		
3	Has the child placed in a residential treatment program?	☐	☐		
4	Has the child placed in a juvenile justice setting?	☐	☐		
5.	Has the child placed in another treatment setting? If so, specify here:	☐	☐		
6.	Has the child receive a diagnose(s)? If so, list diagnose(s).	☐	☐		
7.	Has the child been prescribed medication(s)? If so, list past and present medications:	☐	☐		

Child Dissociative Checklists	*No*	*Yes*	*Score*
Was the child rated on the Child Dissociative Checklist (CDC)?	☐	☐	
Did the adolescent take the Adolescent Dissociative Experience Checklist (A-DES)?	☐	☐	

Research in progress showing strong internal consistency and convergent validity

https://www.waterscounselingandtraining.com/check-list-for-trauma-assessment

Coming in 2024!

Revised

ISSTD's Child Adolescent Dissociative Treatment Guidelines

Current Version; 2003

www.isst-d.org

Perception is Reality:
Helping Systems View
Childhood Dissociation
Through a Complex Lens

Discussion