Narrative Exposure Therapy for Children and Adolescents (KIDNET)

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Narrative Exposure Therapy for Children and Adolescents (KIDNET)

11

Maggie Schauer, Frank Neuner, and Thomas Elbert

11.1 Theoretical Underpinnings of Narrative Exposure Therapy (NET)

Children and adolescents become traumatized when they are repeatedly exposed to negative experiences that are intense enough to trigger an alarm response or another strong reaction of the defense cascade (Schauer and Elbert 2010). The consequences are particularly devastating for mental health if the pain and fear are caused by the attachment figure, because caregivers are meant to provide the opposite of this: safety, reassurance, and calm. Children who experience one type of adversity also frequently experience other forms of stress, which may include emotional neglect, social rejection, and physical or sexual abuse, either within the family or externally.

Multiple experiences of severe stress form building blocks for trauma-related suffering (Neuner et al. 2004; Schauer et al. 2003) that leave their survivors vulnerable into adulthood (Kolassa et al. 2010). Consequently, new traumatic experiences are most devastating when they affect those who have had to endure childhood adversities (Nandi et al. 2015) that have led to permanent changes in implicit memory.

Narrations from child survivors who have experienced severe and often ongoing stress describe immense pain and sadness. These children desperately seek emotional closeness and meaning-making (Schauer et al. 2004, 2005; Onyut et al. 2005; Catani et al. 2009; Hermenau et al. 2011). For survivors of multiple and complex traumatization, stabilization therapies that involve active detachment from the

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memory of the trauma, or therapies which only attend to the trauma incidentally, or select an isolated traumatic event as the target of therapy, have not proven to reduce the resulting suffering in its entirety in these children. Such therapies are insufficient to modulate maladaptive changes in neural and epigenetic organization and will not redirect development toward functionality (Lindauer 2015; Jongh and Broeke 2014; Neuner 2012; Beutel and Subic-Wrana 2012; Elbert and Schauer 2014).

Humans with broken lifelines need a comprehensive approach of narrative restructuring and in sensu exposure not only of their trauma memories but also of their entire biography. Children and adolescents need support to be able to reflect on their life stories and process the traumata as well as their empowering life experiences. *Narrative exposure therapy* (NET; Schauer et al. 2005/2011) focuses on the elaboration of the autobiography, including integration of both the traumatic experiences and other highly arousing events. KIDNET has been designed for minors affected by multiple and continuous exposure to traumatic stressors, such as abuse, social disadvantage, and/or repeated experiences of organized violence. Chronologically guided narration along the timeline with a focus on the most arousing events can be sufficient to provide considerable relief and reinstate individual functioning, even in children who suffer from severe and complex traumatization (Catani et al. 2009; Ruf et al. 2010). Storytelling is universal in child-rearing across cultures. When combined with imaginal exposure, it will allow meaning-making and location of the cascade of traumata in context (Ruf and Schauer 2012). With its testimony approach, NET also aims to document children's rights abuses, within the family and in war.

In traumatized individuals, memory functions have lost their orchestration. Their own biographies seem fragmented, without coherence (e.g., Brewin et al. 2010). Therefore a core component of KIDNET is to assign each traumatic event a corresponding spatial and temporal context (*where* and *when* did things happen?). This autobiographical information is referred to as "cold memory" (Elbert and Schauer 2002). It is verbally accessible and hence supports communication and reappraisal. This allows an adjustment in the meaning of events to occur. Cold memory contains records of conscious experiences that assign context to hot memories, which are the sensory, cognitive, and emotional traces of arousing experiences. In trauma-related disorders, the key problem is the failure of proper connections to the associative hot memories including when and where the experience happened, resulting in feelings of impending threat and helplessness. This leads to lasting posttraumatic stress, anxiety, and depression (Brewin et al. 2010; Brewin 2014; Schauer et al. 2011). As a consequence, the attachment-seeking system in children is overly activated. Their ability to adequately regulate emotions and their motivation to explore and learn are jeopardized because of their decontextualized "hot memories" (Table 11.1).

Emotionally arousing events result in detailed sensory and perceptual images tied together in associative networks (Schauer et al. 2011). Arousing memories – for example, one's first romantic kiss – may be activated by sensory cues such as the

scent of a given perfume or invoke physiological responses such as *heart pounding* in pleasant anticipation. In addition to sensations and emotions, hot memories also include a cognitive component – *am I dating the right boy? My parents will be angry with me*…. For traumatic experiences, hot memories may involve features of the past scene: the sound of bullets, the smell of fire (sensory elements), fear and panic (emotions), thoughts of helplessness (cognition), sweating, and heart palpitation (physiological memories). In traumatized survivors, these memories can only be accessed involuntarily, forming the basis for flashbacks and nightmares related to the traumatic moments themselves. With an increasing number of experiences, more and more sensory elements become associated to this memory (this phenomenon is called a "fear network") and thus act as cues that increase the likelihood that the core feelings of trauma (fear, helplessness, arousal) will become activated. This hot memory network is the result of experiences that were made at different times, in different places, and thus do not share a common cold memory. Consequently, with increasing exposure to stressors, the fear network becomes larger while these hot traumatic memories lose their connections to spatial and temporal information (Schauer et al. 2011). When cues trigger these hot memories, there is no connection to a single episode, and the experience is erroneously located in the here and now.

These cold memory deficits pave the way for frequent arousal peaks and cause nightmares and flashbacks. Children relive events and may replay them over and over again. Therefore in narrative exposure therapy, the survivor constructs a chronological narrative of her/his life story with the assistance of the therapist and with a focus on emotionally arousing experiences. The associative entanglement of the traumatic experiences will be transformed into a coherent narrative, whereby the facts are embedded in the emotions and cognitions that they have elicited in the past and their memory activates in the here and now. Hot and cold memory contents become reconnected (see Table 11.1). Empathic understanding, active listening, congruency, and unconditional positive regard are key components of the therapist's behavior.

Table 11.1 Hot and cold memory

Cold memory (context: time and place of episodic events)	Hot memory (sensation-cognition-emotion-physiological responding)
Abstract, flexible, contextualized representations	Inflexible, sensory-bound representations
Verbally accessible – support communication, reappraisal, and consequent alteration of life goals	Detailed sensory and perceptual images that can be accessed only involuntarily and that form the basis for flashbacks and nightmares
Contains records of distinct conscious experiences that can be activated by both voluntary and involuntary retrieval	Memory is associative and not contextualized, hence traumatic moments experienced as happening again in the present
Can situate information in its appropriate spatial and temporal context – *allocentric*	Supports *egocentric* view only

Brewin and colleagues (2010; Brewin 2014) point out that evidence from both cognitive psychology and neuroscience confirms distinct neural bases to abstract, flexible, contextualized representations and to inflexible, sensory-bound representations. The latter is primarily supported by areas of the brain directly involved in perception (e.g., representational cortex) rather than in higher-order cognitive control. The lack of involvement of structures such as the hippocampus results in a non-contextualized memory that is experienced as reoccurring in the present. Contextualized representations contain records of conscious experience that can be activated by both voluntary and involuntary retrieval and also support communication, reappraisal, and the consequent alteration of life goals. This system can situate such information in its appropriate spatial and temporal context. Verbal expression supports the ability to deliberately retrieve and reorganize memory representations and reconstruct them from the low-level sensation-based memory and its corresponding representations.

In this way, the method of narrating those experiences that have the highest arousal peaks across one's entire life does not require the individual to select a single traumatic event from their multifold history of trauma. It rather acknowledges their human life as a whole and helps a child to reclaim ownership of their autobiography. Instead of focusing on an index trauma, KIDNET embraces a life-span perspective. Severe trauma, whether it is the result of an act of nature or deliberate human cruelty, challenges basic assumptions about the world and our expectation to have control over our lives. In developing individuals, repair of attachment wounds can occur, while the emotional networks are activated during narration, if the child encounters a therapeutic contact that guarantees warmth and empathy. KIDNET helps children to chase their ghosts away. They are able to put good and bad into perspective within their stories, experience reparative adult emotional support, and put their thoughts and feelings into words in order to heal the trauma. Instead of therapeutic neutrality, KIDNET promotes advocacy and children's rights for survivors.

11.2 How to Do KIDNET

The classical narrative exposure therapy (Schauer et al. 2005) approach is divided into three parts, and so is KIDNET (for details see Schauer et al. 2011):

KIDNET Treatment Plan Overview

- Part 1: *Assessment and psychoeducation*: Structured diagnostic interview including *trauma event checklists*, followed by a *brief psychoeducation* for the child and the caregiver in one or two sessions (each about 90 min)

- Part 2: *Lifeline exercise*: Laying out the lifeline as an overview of the highly arousing positive and negative life events along the biographic timeline (done in one session with about 90–120 min)
- Part 3: *Narrative exposure*: Chronological narration of the whole life story including imaginal exposure of the traumatic events (90 min sessions, number of sessions should be determined after the lifeline excercise and typically may range from five to ten). At the end of the treatment, rereading of the whole testimony in a final session and signing of the document by all witnesses and the survivor or laying out a final lifeline including symbols for hopes and wishes for the future. Handing over the life story to the survivor (and his/her non-offending parent)

11.2.1 Part 1: Assessment and Psychoeducation

11.2.1.1 Step 1 (Optional Component for Preschool and Primary School Children, Without Parent)

Build rapport and assess what is immediately on the child's mind – grasping implicit, sensory memories ("hot" memories)

To build rapport with a child, it is often helpful to ask the child to draw a picture or arrange small toys and play with them. When asked to draw a picture, a traumatized child frequently presents an image of its associative trauma memory – that is, the picture fuses elements from various traumatic experiences, sometimes combined with monsters from the fantasy world.

A therapist may introduce her/himself by saying:

> My name is Nell. I am a psychologist (doctor, nurse, social worker etc.) from the (clinic, university, school, etc.). I am here to help children who have experienced extremely bad things such as (use example as useful: war, rape, forced migration, torture, massacre, accidents etc.) and to write down what happened. Before I talk to you about your experiences and the pain that children feel when bad events happen, I was wondering if you could draw a picture about whatever is on your mind or bothering you right now.

The therapist stays in close emotional contact with the child and verbalizes what a child draws or displays with materials. If the child shows something that is obviously related to a bad experience, the therapist tells the child that she/he wants to know more about the bad things that have happened. They may continue with step 2 (a checklist) by explaining that people may experience many bad things and that it is good to know what has upset the child and is probably still bothering her/him. If the child draws something that is not likely to be related to a trauma, the therapist also validates the child and shows interest by asking about the content of the picture before continuing with step 2.

11.2.1.2 Step 2 (Mandatory): Structured Diagnostic Interview Including Event Checklists with the Child (Without the Parent)

KIDNET allows a stepwise approach to disclosure of trauma material. At the beginning of treatment, survivors of trauma are typically avoidant of reminders of their traumatic experiences. However, simply agreeing or disagreeing to an item list, and indicating *when* and *where* things happened, is possible for the majority. An allocentric position (external viewpoint asking for cold facts and context information) will allow the child to feel in control and will not be overwhelming. A thorough and engaged clinical interview (assessment) is essential and will begin the process of establishing a therapeutic relationship.

We recommend using a checklist for assessing both traumatic experiences and other stressors that the child might have experienced within and outside the family. For typical events, the "pediatric Maltreatment and Abuse Chronology of Exposure" (pediMACE; Isele et al. 2016, available in English and German from the authors upon request) has been proven to be a useful tool for schoolchildren of all ages. Introductory items provide information about the familial constellation and the living environment of the child. The child is then asked to respond with "yes" or "no" if he or she has experienced any adverse social situations. Depending on available time and resources, experiences are temporally anchored within lifetime periods – for instance, stages of formal education (kindergarten, primary school, etc.), places of living (my hometown, refugee camp, etc.), or other suitable references. Similar experiences at different ages can be ranked. Inclusion of positive formulated items complements this list in order to remind the child that there were not only bad moments in life. In this way, the pediMACE is a list of typical adversities that normalizes the child's experiences (since they become "known" to the therapist) and legitimizes the reactions to traumatic stressors. The measure asks for the following interpersonal events that are relevant for trauma treatment: parental emotional violence (adults living in the household), parental physical violence (adults living in the household), emotional violence by siblings (children living in the household), physical violence by siblings (children living in the household), emotional neglect, physical neglect, witnessing interparental violence (adults living in the household), witnessing violence to siblings (children living in the household), peer abuse (physical and emotional), sexual violence, and parental loss.

For children who have additionally been exposed to organized or community violence and/or other traumatic experiences such as natural disasters, corresponding checklists should be used. If the child reports stressful experiences, a diagnostic instrument for PTSD such as the UCLA Child PTSD Reaction Index (DSM-5 version: Pynoos and Steinberg 2013) should be applied. Depressive symptoms and suicidality must also always be considered.

Case: T. was 15 years old when she was referred from the school psychologist to a child psychiatric ward because of her eating disorder and, from there, to our outpatient clinic. She was clearly underweight when she first presented. Her school performance had worsened over the course of the last year, with impairment in cognition and memory as well as learning functions, and she had begun to skip more and more school days. She was unfriendly to teachers and peers, was using cannabis, and was uninterested in social activities. She presented at our unit together with her mother, who was seeking close contact to the staff and was very emotional and overly grateful for the possibility of treatment. The mother was suffering from borderline personality disorder and had occasionally been in psychological treatment at other institutions.

The event checklist revealed that T. had been left alone and neglected many times at a preschool age by her mother and later had been sexually abused by her father who was divorced from the mother. In addition, due to the unsettled life of the mother, the family moved many times during her childhood. She had also suffered a severe car accident. After the structured interview, T. was diagnosed with PTSD, depression, and suspected cannabis use disorder.

11.2.1.3 Step 3 (Mandatory Step, with the Presence of a Non-offending Caregiver): Psychoeducation

In KIDNET, psychoeducation is an ongoing companion to treatment, framing the experiences and increasing understanding of symptoms and the rationale for treatment. It is typically repeated briefly and focused on the area of difficulty. After completing the assessment, trauma reactions are explained to the child and his/her caregivers in an open and transparent manner. Introducing the trauma checklist and explaining why it is useful to know what trauma does to the individual, the family and the community informs the child and the caregiver about why they are suffering from distressing events and what can be done about this. This allows the family to regain a sense of control over the symptoms and hope for change.

The therapist provides a detailed explanation of the symptoms using age and education appropriate language and without using medical or scientific terms.

Example:

> After the many events you have experienced, most children would be upset. This aftershock is known as a post-traumatic reaction. Our mind and body are designed to notice and remember dangerous information since when there are lots of scary things happening, it may be better for us to be too careful and very aware of what might be happening nearby,

in order to keep safe. This survival strategy has become part of yourself, but it is painful and extremely tiring, as you know.

A psychoeducation introducing KIDNET could be as follows:

In order to successfully control the terrible memories from moments when you were fearful in your life or got hurt, we need to gain access to these past events. Together, we want to look at the thoughts, feelings and bodily sensations you had when you experienced … (incidents). I'll help you tell your life story and write everything down. When exploring these bad moments in slow motion, they will lose their power and remain where they belong: in the past. We call what has happened to you a violation of your child rights. You should know that nobody is allowed to violate or harm a child.

Adolescents will need a clear and full explanation about their trauma experience and the treatment plan (which can be given in the presence of their caretakers). Example for psychoeducation with adolescents:

No matter how hard survivors of such terrible experiences try to push them away, memories come back: they intrude into their lives, during the day and in dreams at night. All of a sudden, the person may become upset, scared or detach herself from reality. All of this happens without really knowing 'why'. During a terribly horrifying moment, our mind cannot understand what is going on. It is just too much. We become highly aroused in order to react quickly and make sure we survive if we can, or we feel like fainting, but we have no time in these moments to process any of this information. However, our memory brings up these feelings and fragments later on in order to understand, digest and put together all of this until it makes sense. Reliving those feelings, pictures, and bodily sensations shows that the mind is trying to process this horrible event, to make it understandable – because this may be vital throughout life.

What we want to do now is to give them room here during therapy. We want to explore them together so that they lose their horror in the presence.

For small children the therapist can use metaphors for "cleaning up" the memory to help children understand the rationale for the therapy: like the example of a "stuffed wardrobe," where things pop out (intrusions) and will only stay inside, when the items are taken out, sorted, and folded back in, or the example of a wound that is infected and hurts when touched, which needs to be opened up again, disinfected, and then healed. Sometimes, it might even be helpful during psychoeducation to draw the associations of the child's fear network (Schauer et al. 2011) and see how the different sensory elements (seeing, hearing, touch, etc.), thoughts, feelings, bodily reactions, and meanings are connected to each other.

The psychoeducation should result in the child obtaining the following:

- A helpful explanation about their suffering
- A clear understanding of what will happen during treatment and that she/he is invited to participate voluntarily
- An explanation of what is expected of him/her in the process of KIDNET
- Answers to any remaining questions the child may have about the therapy

In older children it is important to explain why talking about the traumatic event can help to overcome the person's suffering and that giving testimony is an important step in documenting the violation of children's human rights and gaining dignity.

Case report (*cont.*): In the case of T., it became apparent that the mother did not know about the sexual abuse her adolescent girl had suffered as a child. Together with T., we thoroughly prepared how we wanted to tell this information to the mother. After that, the mother was invited into the room.

During the psychoeducation step, we explained to the girl and her mother what we had found in the diagnostic interview, normalizing the reactions to the childhood stressors and the current behavioral problems of T. Afterward, we assured the caregivers' support for the planned trauma-focused treatment and detailed the concept of KIDNET and the rationale for treatment.

The mother agreed to take the topic to her own therapist in order to come to terms with the disclosure of her daughter.

11.2.2 Part 2 (Characteristic Part of KIDNET): *Lifeline*

In the next session (allow about 90 min, without the presence of the caregiver), the child's individual life history will be displayed on a timeline, by taking a bird's-eye view of his or her life. This step, also performed in an allocentric position, helps structure the fragmented memory by organizing the life experiences as symbols chronologically along the timeline.

A piece of rope or ribbon is put to the floor or on a table (for physically challenged children) and unfolded by the individual. One end of the rope represents "birth," the unfolded line itself represents the course of life, and the other end should be rolled up to indicate the future yet to come. With the help of the therapist, the young person starts to place natural items that represent memories of significant emotional events along the lifetime periods on the *lifeline* (see Fig. 11.4). In this way they systematically organize all of the memorable biographical events (see Schauer et al. 2011; Schauer and Ruf-Leuschner 2014): "stones" represent moments of negative valence (e.g., fear, horror, sadness, loss) and "flowers" represent moments of positive valence (e.g., joy, love, achievements, important people). In addition, there are two more symbols representing distinct dynamics: sticks for active involvement in aggressive acts (*acts of violence or appetitive aggression* like, e.g., perpetrating acts, fights, delinquency, killing, combat) and, if desired, candles for moments in life when the child experienced a loss (i.e., *grieving*).

The therapist accompanies the process by empathically verbalizing what is being laid down, finding suitable labels (titles, descriptions) for the symbols, and making sure that the cold memory system is activated and contextual information is added during this exercise: "what happened?" (e.g., death of my mother in the hospital);

"when did this happen? how old were you?"; and "where did this happen?". Hot memory information is not requested during the lifeline exercise. Gentle encouragement by the therapist is necessary to clearly frame the different events in this manner.

The *lifeline* exercise should be completed in one 90-min session followed by a brief review of the session. The therapist may take a picture of the completed *lifeline* or let the child make a drawing on a piece of paper with colored pencils and note the text of the labels (title, age/year, and place).

Case report (*cont.*): The therapist placed a flower symbolizing T.'s birth at the beginning of her lifeline. (Note that all other symbols are placed by the client herself). T. explained that she was born to a family with mother (name), father (name), and brother (name and age) and they lived in (name of town). She placed a flower for her brother, who she loved a lot. At the age of 3 years, there was a stone for her witnessing domestic violence. At 5 years old, her parents got divorced and T. had to spend weekends with her abusive dad. She remembers crying when she had to see him. T. placed a stone for the first event of sexual abuse at this age and two more events for which she had distinct memories. Then, she put a flower for pleasant memories in school, followed by a stone for when the family moved to another country, cutting her off from her friends. This was followed by two flowers for her two dogs whom she loved a lot and then later, at the age of 10 years, two stones because the dogs were put down when the mother again moved with her to a different country. Another stone for the time when she was hit by a car (stone, 11 years old). Every now and then she had been sent to her father, having to spend holidays with him. The father introduced his daughter to child pornography and sold her at sex parties. T. placed different big stones for discrete memories and dates of such violent events at that age. With her brother T. started to smoke cannabis when she was 12 years old. Another stone was placed 1 year later, representing when the police came to their home to arrest her brother. At the age of 13, she joined a gang and they started to rob petrol stations and old people on the street (sticks). T. laid down a stone for a very emotional moment at this age: her mother severely beat her, shouted at her, and called her bad names when the girl tried to tell her mother about the sexual abuse. After the beating, the mother broke into tears and apologized. T. began to starve herself, losing more and more weight. A stone was placed for when she was admitted to a psychiatric hospital (age 14). The mother and her boyfriend smoked cannabis in the house and offered the substance to T. because they believed that this would increase her feeling of hunger and make her eat. T. felt betrayed (stone). Her school performance worsened. An edgy stone for her first romantic experience that failed (15 years) and, as a consequence, massive intrusions and flashbacks of the sexual abuse started. Finally, a flower was laid for the

very kind and understanding school psychologist who listened to T. for the first time in her life. On the future part of the rope, she placed flowers for the "hope to overcome her trauma symptoms" and her "wish to play more guitar music" and develop a vision for a good future.

11.2.3 Part 3: Narrative Exposure (Mandatory)

In the next step, the core procedure of KIDNET begins. The survivor (without the presence of the caregiver) starts narrating his/her whole life over several treatment sessions (allow 90+ min per session) along the chronology of the *lifeline*. The sessions with narrations may begin with another brief psychoeducation:

> As you know, we want to construct a detailed, comprehensive and meaningful narrative of your good and bad experiences. We want to fill in all the gaps until the testimony is complete, the bad feelings and the pain dissolve and the fear goes down. Our experience is that the more complete the narration gets, the more you can understand about what happened to you and the more the suffering will decrease. We will always go along your life's timeline: we will proceed step by step as the event unfolds. After this, we might go over it again, correct and complete things if we need to, until we reach a final version within a few sessions. However, each individual session will always be taken to the end of the event. It will last about one-and-a-half hours each time. We will take enough time at the end of each session to make sure you are comfortable.

The therapist might want to provide a much simpler explanation for younger children, for example:

> You are already 8 years old now and you have listened to and watched many stories about others. These stories are exciting or wonderful, but also scary, wild and dangerous sometimes. Have you ever told your own story? I would like you to tell me what happened in your life. You report your events and I will imagine what it must have been like to experience these moments. I'll write it down and then you can listen to it and even correct it. We'll make a little book about you, with the picture of your lifeline on the front cover. We'll talk about all the good and the bad experiences to make the bad dreams go away. Later, we can see together whom you will allow to read the book.

The different symbols – which were previously placed on the *lifeline* – each represent a specific event. Now, during the *narration* part, the individual is asked to elaborate on the different situations of fear, joy, aggression, or grief. The therapist's intervention differs with the type of symbols:

1. *Stones*, the representatives of traumatic events, are the focus of the therapeutic attention in KIDNET. Each scene gets processed using imaginal exposure.

Negative arousal needs to be low at the completion of a successful session dealing with a "stone."

2. *Flowers*, symbolizing important relationships, joyful experiences, achievements, and other resources, are closely described and partially relived, although not in as much detail as stones. Positive arousal may carry on at the end of the session.
3. *Sticks*, representing one's own aggressive acts, are processed with a full imaginal exposure in order to contextualize the aggressive acts and explore the associative network. The therapist searches for mixed feelings, moments of ambivalence, and emotional arousal. The therapist fully accepts the reported feelings, even when positive. Role changes and moral systems need to be discussed after completion of the narration (see FORNET, Elber et al. 2012; Hecker et al. 2015).
4. *Candles* for situations of losses and social pain or rejection are reported and mourning is assisted. Such narratives resolve an important paradox: stable contact to the lost one is achieved (through use of reliving and rituals), while at the same time a "letting go" process is facilitated.

Narrating a highly arousing event means continuously exploring different levels of experience with the support of the therapist while the report progresses (for details, see Schauer et al. 2011): sensations ("what did you see, hear, feel, smell perceive, etc.), cognitions ("what did you think when you experienced …?"), emotions ("what did you feel when you were sensing, thinking…?"), physiology ("what was your bodily reaction when you experienced…?"), and meaning ("what did these sensations, thoughts, emotions, bodily reactions mean to you?"). At the same time, continuous explicit verbalization of the experiences in the "here and now" needs to be enabled while narrating (Fig. 11.1).

In every *narrative exposure* procedure and especially when survivors are prone to dissociate, the here-and-now sensations and experiences need to be reinforced and consciously made tangible *while talking about the past.* This is a crucial step to ex-posure (lat.: step out of) from the past event and to enhance the contrast between the trauma material and the present. Often, sensations, thoughts, emotions, and physiological responses are similar or the same as they were in the past when the associative memory network is triggered in the present. Therefore, the therapist can stimulate talking about the trauma material by drawing from the current bodily responses when thinking about it in the here and now. At the same time, it is made clear that these sensations come from the past, they just feel as if it is happening in the here and now. The child is encouraged to continuously experience with dual awareness: switch between the past tense : "what did you experience then (on the different levels)…" and the present tense: "what do you experience in the here and now when you think and talk about the past event?". Counteracting shutdown responses and a guided pendulum motion between the contexts is advisable if a child is prone to dissociate (see Schauer and Elbert 2010). This creates a sense of safety and allows detailed exploration of the trauma material and full imaginal exposure.

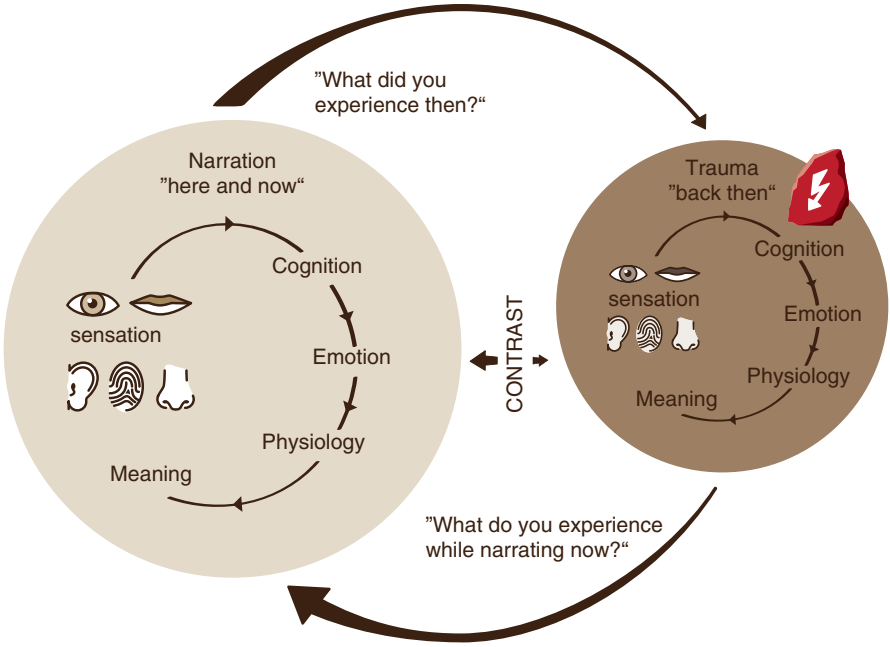


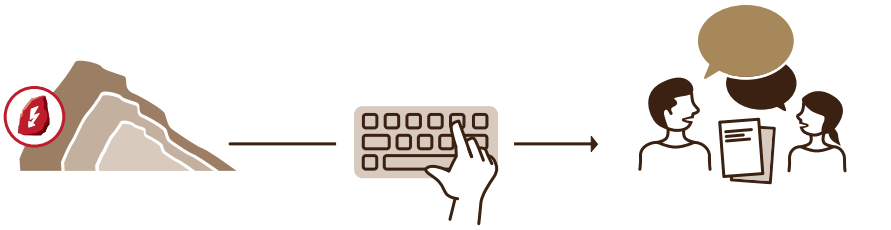
Fig. 11.1 The method of the NET narration procedure. During the imaginal exposure, the different levels of experiencing are continuously explored in detail while the child tells the story. Every now and then, the therapist invites contrasting the past (trauma) context from the current context (Schauer et al. 2011)

The therapist makes sure to support the young individual in the following two ways:

- Allowing time to fully activate the emotional network associations of the hot memories and helping to put the experiences into words
- Conscious contrasting (time, place, setting, sensations, cognitions, bodily responses, emotions, etc.) of the two levels of living through these experiences (level "then," the past event, versus level "now," the imaginal exposure to the memory) is key for integrating the experience.

In this way, a thorough narration of the young person's biography is constructed which is very detailed for highly arousing moments in life and briefly summarizes life in between. The therapist supports the imaginary reliving and emotional processing of the traumatic events and the chronological structuring of the fragments, taking an empathic and accepting role. The therapist writes down the child's testimony. In the subsequent session, the material is read to the client, and the child is asked to correct it and to add further details (Fig. 11.2).

Children enjoy talking about joyful moments from their childhood. For many people who have been exposed to childhood abuse, organized violence, and war, the



Narrative exposure session:

processing of traumatic events: the arousal decreases during imaginal reliving and the therapist makes a transcript of key points

Between sessions

therapist structures the narrative and transcribes the oral account; therapist takes a draft copy to the next session

Re-reading at the beginning of the next session:

another in sensu exposure is facilitated by going through the narration together; the text is corrected and more details are added, with the active participation of the child. Afterwards the narration of the life-story is continued …

Fig. 11.2 The process of narrative exposure: Imaginary exposure session, writing down the narration after the session and rereading the text and providing another possibility for exploring the content in the consecutive session (see Schauer 2015). After the rereading, the narration is continued chronologically along the timeline

memory of good moments in their life has largely disappeared. Remembering and reliving memories of positive experiences, moments of mastery, or important relationships can mean a lot to survivors of adversities. The therapist should include accounts of the "flowers" of life as well as all the other important experiences. Situations involving social pain, grief, and loss receive particular consideration, respect, and warmth. The experiences are explored in the same way by asking for sensations, cognitions, emotions, bodily responses, and meaning while the narrative evolves. It is important to show empathy and allow for corrective relationship experiences. The child is aided in keeping in mind the distressing and painful details of the memory until the physiological arousal decreases. In this way, a detailed report about the traumatic event is constructed in chronological order (Fig. 11.3). The child/adolescent needs continuous positive validation for his/her courage to work through these highly arousing events.

During the narrative process the attention of the therapist focuses on the following:

- *Time*: Establish *when* the incident took place. Begin with the lifetime period (e.g., *when I was going to primary school*). Then, proceed to the particular moment of the hot spot. Spend most of the exploration narrating around the highest arousal until it decreases.
- *Location*: In parallel with the time, establish *where* the incident took place (e.g., *when I was still living in my hometown*). Where was the person at that time? Then proceed to the specific location (e.g., *when I was passing in front of the town hall...*).

- *Arousal*: Start working through the incident as arousal rises, viewing all of it in sequence. Go in "slow motion" as the arousal gets higher. Make sure that any fear-provoking associations do not overwhelm the child nor that the individual is under-engaged. It is necessary that the child is emotionally activated and involved. The physiological arousal should stay within an optimal window of tolerance and functionality. During high arousal, the hot memories will be detailed; these must be explored and connected to the contextual, cold facts. Therapists may use a rough drawing of the situation or figurines to replay the scenes that had happened during the traumatic events (an allocentric view on the scene engages the cold memory system). The therapist, in alliance with the young survivor, needs patience and tenacity to explore the hot spots and their significance on the different levels (sensations, cognitions, emotions, physiology, behavior, etc.). Arousal should decrease for each trauma scene (processed chronologically), and the reporting of traumatic moments becomes increasingly tolerable. In this way the child is soon able to hold the traumatic event in mind and talk about it in a comprehensive manner and listen to the narration while all aspects are illuminated. The therapist should not allow a reduction in tension to occur just because the child avoids parts of the event that are painful. Quite the opposite: Allow enough time to explore the meaning of the worst moments. Often, the factual report about the course of the event does not automatically reveal what it meant for the survivor and how it impacted on the mind. However, detailed analysis of the meaning of the event should not distract from continuing to talk through the stone. Verbalizing the painful injury of the person that took place on the level of meaning requires the full support of the therapist.
- *Awareness – then and there vs. here and now* (*dual awareness*): When the child is recalling the event, help him/her to focus on what they perceived at that time (e.g., senses, thoughts, actions at the time), and contrast it to what they are experiencing now during the narration (see Fig. 11.1).
- *Reinforce reality*: Prevent avoidance, dissociation, or flashbacks by orienting and grounding the child to the present with the help of sensory cues, such as "can you feel the chair you are sitting on… touch the texture," "while you think about the past now, can you briefly tell me what is in the picture in our therapy room here – describe items in room," "outside there are people walking in the aisle, please tell me what you can hear," etc. Short interventions of this kind should not prevent continued exploration of the event: "Good, you can hear people having a conversation outside the room in our clinic here in Konstanz. But at the time, when you were hiding in your house in Idlib during the war, you could hear the sound of explosions..." (Fig. 11.1).

In this manner, the life review moves forward until a full version of the individual's biography is complete and the story has reached the present day (Fig. 11.3). In the last session, the whole narration is reread to the child, or a final overview *lifeline* is laid out (Fig. 11.4). In the case of multiple (different) traumatic events, a rereading of the whole document makes sense.

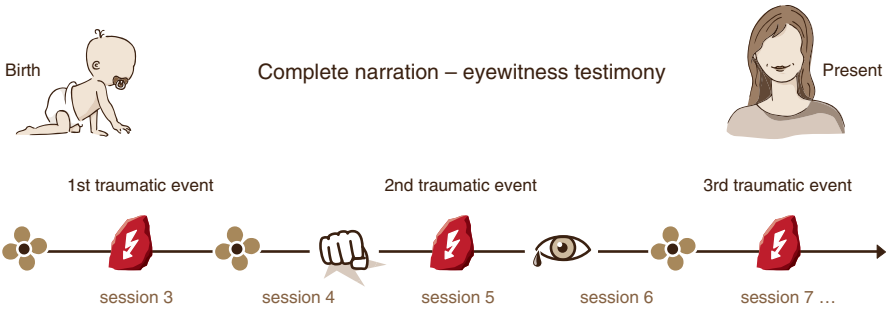


Fig. 11.3 In NET/KIDNET, the whole life of the individual is chronologically narrated from birth to the present time, highlighting the highly arousing moments of positive and negative valence including traumata, achievement/resources, loss/grief, and one's own aggressive acts

Case report (*cont.*): When T. started telling her life story, she was very excited and interested to explore all the details of the incidents. She was well able to tolerate all the feelings that came up during the narration and quickly learned to pay attention to the different levels of processing (sensations, cognitions, emotions, physiology, meanings of these sensory experiences, thoughts, feelings, bodily responses) as well as contrasting "then and there" with "here and now." She enjoyed the unconditional attention of the therapist guiding the session. The narration of each last session was reread each time at the beginning of the next session, allowing further completion and giving a natural chance for a second reliving and meaning-making. In this way, the therapeutic process progressed smoothly.

T. showed up punctually to her treatment sessions until we came close to the events of the sexual abuse by her father. The first time she talked about the sexual violence, she avoided the start of the narration and involved the therapist in a discussion about false memories. After some time, the therapist gave a brief psychoeducation and gently directed the attention of T. back to the task of exploring the traumatic event. Concrete contextual questions helped get this started. "On which day did your father first violate you?", "Can you describe the room, the time of day, the beginning of the event – were you already wearing your night gown when he came to your bedside?..."

Slowly and precisely, T. started narrating the scene. Whenever her memory went blank and she was unable to retrieve pictures, focusing on her bodily arousal and sensations helped to tell the story and allow progress. T. started

crying when she remembered the helplessness and pain she felt at the time and she could feel some of the anger now, which she had to suppress in the presence of her father at the time. The story was taken to the moment after the abuse had ended when her father had left the bedroom in the past event and a point of relative safety and relief was reached.

Although physically tired at the end of the session, T. expressed her surprise about the clarity of the recovered memories and felt unsure of whether she should be embarrassed or relieved. The witness gave personal feedback and normalized feelings of shame and guilt.

The next session was canceled by T. because she had confronted her mother with the sexual abuse for the first time. This was very frustrating for her, since initially the mother claimed her experiences were only fantasies. However, the more elaborate and precise her memories became, the more safe T. felt. In the following weeks, the girl started to trust her assignment of bodily reactions to their emotional memories, and over time, she developed a stable sense of self.

At the end of T.'s treatment, both mother and child were invited to decide how to go about the testimony document and juridical case of child abuse and to talk about T.'s future.

However, in the case of complex trauma with many of the same events (such as sexual abuse), the detailed rereading at the very last session can be replaced in favor of a final *lifeline* session. Alternatively, both can be done: the child places the symbols on the *lifeline* one after the other and the therapist chronologically rereads the according parts of the narration. In a final *lifeline* session at the end of treatment, the child may want to place flowers for hopes and wishes for the future on the *lifeline* ("I hope to see my family again after the war," "I wish that my sister would recover from her illness," "I want to graduate well from school and become a doctor," etc.).

In any event, the child survivor and all witnesses such as the therapist, interpreter, or co-therapist sign the final testimony in the last session. The eyewitness report may serve as a document for child rights and human rights violations or be used for juridical and awareness-raising purposes or be electronically archived for later use.

Fig. 11.4 *Lifeline* with symbols for specific experiences and with flowers for hopes and wishes concerning the future

Case report (*cont.*): Initiated through the lifeline approach and continued with the biographical narration, T. could reflect on her life as a whole and recognized recurrent themes and patterns, such as the neglect and pain she had endured and how she had started suffering and coping with emotional and behavioral responses. Activating her terrifying lifetime memories in the safe and empathetic encounter with a caring listener, T. experienced corrective relationship contact and felt emotionally supported.

Over the course of the coming year, T. was invited every 3 months for a follow-up interview at our clinic. The interviewer observed that her motivation for school performance significantly increased in parallel with the remission of trauma symptoms and her ability to feel and act progressively independent from the emotional state of her mother. Her intrusive symptoms (terrifying nightmares and genital pains) remitted together with the nausea (feelings of disgust) and her inability to consciously recall the sexual abuse (avoidance). Even her feelings of estrangement toward other people decreased,

and she started experiencing a sense of belonging. T's environment responded positively to her changes, and she felt more and more integrated and accepted in her peer group.

For the last appointment, she surprisingly brought her guitar and sang a self-composed song called "Worte finden" (transl: finding words) to her therapists about the loneliness and entanglement of maltreated children who love and hate their abusive parents and do not know how to reach independence, since they are caught up in such guilt and shame. Upon leaving, she expressed once again her gratitude and surprise about this new experience of not having to fight her own inner world, but actually receiving support from another human in the presence of strong emotions – both good and bad.

11.3 Special Challenges

Trauma-related suffering results from the cumulative exposure to traumatic stress, and as we indicated above, the logic of KIDNET requires reprocessing (contrasting the imaginal reliving with the feelings in the here and now through narration) of all major "stones" and "flowers" in a person's life. Children have a shorter lifeline, generally with fewer traumas, and their brains are also more plastic. Therefore, treatment may seem easier than with adults. On the other hand, the imaginal exposure may be more challenging in smaller children, since they very actively have to expose themselves to the memory in their imagination. In addition, meaning-making requires insights into life and knowledge of perpetrators' motivations that a child may not easily have. For instance, a 7-year-old cannot understand the meaning of sexual abuse and its effects this trauma may have later in life. The therapist is particularly challenged to respond to the individual development stage and to explain things in simple words and a transparent manner without avoiding (Ruf and Schauer 2012). A seventeen-year-old, on the other hand, may want to seek justice and revenge, again without fully comprehending what it may mean to go to court against, for example, a family member. Therefore, the use of the testimony cannot simply be left to the child without further counseling. In KIDNET, the therapist may need additional sessions to discuss what the experience of, for example, sexual and gender-based violence means in general and to the child in particular. Based on this knowledge, the child, the caregiver (if appropriate), and the therapist may discuss how to use the testimony. The therapist, for instance, may suggest that the testimony only be used in an anonymous form so that others are protected from experiencing such a fate.

PTSD in childhood is particularly harmful, as it is associated with behavioral disorders, learning difficulties, and crime-related conduct throughout life. Within a

healthy family, the parents and siblings may provide useful resources to cope with this problem once the PTSD symptoms have dissipated. Family members may be instructed accordingly, indicating, for example, that externalizing behavior is a consequence of traumatic experiences rather than a basic trait of the child. Parental psychopathology results in a more difficult situation and has been found to impact the parent-child interaction and the infant's development. Emotional neglect, abuse, and inconsistent parenting by distressed caregivers play a key role in lifelong mental health problems, health risk behavior, and psychopathology in the parents of tomorrow who are raised under conditions of continuous trauma. Narrations – even transgenerational ones (those that start with the time before the child was born) – can be helpful for children to find an explanation for their caregiver's reactions.

11.3.1 When Parent and Child Are Both Traumatized

When both parent and child present with PTSD, several components of treatment may be carried out with both (non-offending) parent and child being present. In such cases, the focus of the treatment is the dyad (parent-child) that is needed to reconstruct a *lifeline* starting from the moment of their common life experience and thus the moment of the child's birth. Therefore, the caregiver is the one that starts the *lifeline* and she/he is asked to place the events she/he has experienced since the child was born up to the moment the child has its first memory on the line. Then, the child is asked to participate in the reconstruction of the lifeline. The procedure must be dynamic and permit parent-child interaction while placing the common events on the *lifeline*. The parent is instructed to intervene in a non-invasive manner; thus, repeated interruption of the reconstruction must be avoided, and the child in return needs to be allowed greater initiative to reconstruct the lifeline. Parts 1 and 2 of the treatment can be carried out together with the parent-child dyad.

At present, there are only a few unpublished case reports suggesting that a child's narration can also be observed by a parent who does not intervene, but complements the narration whenever the child is confused or not certain about the course of some events. Often though, it is useful to process this part of the treatment in separate sessions for the parent and the child.

A parent-assisted narrative can be useful if the caregiver is a non-offender and sensitive and able to help the child reconstruct events that have been experienced in early childhood and if improvements in the parent-child relationship as a subordinate treatment effect is desirable. Furthermore, this is the case if a framework is offered in which both are invited to share experiences that have been a subject of avoidance. The dyad also allows for the modification of dysfunctional meanings of the events together with facilitation of cognitive strategies and challenging of maladaptive behavior. In this way the trauma-focused treatment would naturally combine with cognitive interventions for parent and child. A conjoined narration will result from the narration of common experiences.

11.3.2 Prevention and Community Work

Short-term trauma-focused public mental health interventions on a larger scale are required at the community and societal level (Schauer and Schauer 2010) in order to (1) reach an even greater number of survivors and their families and (2) stimulate a societal change that helps prevent further child abuse and other atrocities. Individual narrations (testimonies) detailing acts of violence are potentially of significant value in holding accountable those who are ultimately responsible. Such testimonies have not only been instrumental in international and domestic tribunals specially constituted to tackle war crimes and crimes against humanity but are also of potential use for changing the behavior of the communities at large. KIDNET can produce detailed written testimonies that may serve as an intervention on the community level, helping to assemble collective narratives. In this way, trauma and suffering will be acknowledged (an important healing agent common to all evidence-based individual trauma therapies; Schnyder et al. 2015), and reintegration of both perpetrators and victims may be facilitated, where otherwise both may be treated with suspicion or rejected.

The enormous impact of violence and trauma spectrum disorders on populations drives mass refugee migration (Schauer 2016). The inclusion of robust, low-threshold, and efficient treatment modules like KIDNET in resource-poor environments or countries that host high numbers of refugees is an indispensable component within task shifting "screen and treat" cascade models of care (Schauer and Schauer 2010). Children and their families (Schauer et al. 2014) involved in war, flight, or continuous trauma scenarios (e.g., townships, reservations, or refugee and detention camps) need to translate their experiences into transgenerational narratives in order to avoid haunting legacies and allow healing and integration.

11.4 Research Evidence

The first case of a child war survivor treated with KIDNET was described by Schauer et al. (2004), and further cases with excerpts from narrations and a pilot study were presented by Onyut et al. (2005). Results showed a substantial reduction in trauma-related symptoms at the end of treatment. Clinically significant depression had remitted to nonclinical levels.

Evidence for the effectiveness of KIDNET in children, adolescents, and young adults is summarized in Schauer et al. (2011) and includes randomized controlled trials with between-group design. Superiority was demonstrated in comparison to active (e.g., Catani et al. 2009, Sri Lanka; Ertl et al. 2011, Uganda) and inactive (e.g., Crombach and Elbert 2015, Burundi; Ruf et al. 2010, Germany) control conditions in regard to the reduction of PTSD severity/diagnosis and related disorders. Within the group, effect sizes were large, ranging from a Hedges $g = 1.3$ (Ruf et al. 2010) to a Cohen's $d = 1.8$ (Catani et al. 2009), whereby about 80% (Catani et al. 2009) no longer fulfilled PTSD criteria following treatment. Thus, the family of NET therapies has proven to be effective in quite different cultural settings.

Dissemination and re-dissemination trials, including multilayered stepped-care models for large population sizes, have been effectively implemented since 2003 for NET (Neuner et al. 2008; Jacob et al. 2014; Köbach et al. 2015) and KIDNET (Schauer 2008).

Finally, Hermenau and team (Hermenau et al. 2011) treated orphaned children who had been traumatized by domestic violence in the family and also institutional care. Using a long baseline, results showed that KIDNET produced a significant reduction in symptoms which could be sustained, while a new and nonviolent instructional system was introduced in the orphanage in response to the content of the narrations. In young adult orphans who had survived mass human rights violations and genocide, KIDNET showed significant reductions in symptoms of PTSD, depression, and guilt (Schaal et al. 2009). Currently there are multicenter RCTs in usual care settings under way to study the effectiveness and mechanisms of change caused by KIDNET (e.g., Kangaslampi et al. 2015).

KIDNET is a useful and evidence-based intervention that therapists can adapt to fit to the individual needs of a traumatized child. It can be combined with other forms of assistance. However, to use just parts of it, such as the lifeline as a standalone technique, is neither justified by evidence nor by the theoretical background. In fact, we recommend orienting individual treatment toward the theoretical goal, tying each cue of the trauma-associated memory with the context and meaning.

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